Association of Directors of Public Health (ADPH)
English transition 2012 update survey – summary results

All DsPH in England (147) were sent the survey. Of these 114 (78%) are substantive with 33 (22%) Acting, Interim or Associate. We received **77 (52%)** responses giving their updated views on specific issues around the transition of Public Health from NHS to LA. There was a spread across England with responses from every region. Of those responding, **58 (77%)** are substantive DPH reflecting the national picture.

ADPH is confident that the results below reflect the divergent views of individual DsPH yet give a robust consensus for the Association to support many policy decisions whilst highlighting the inherent risks and suggesting mitigating actions.

Where do you see yourself in 12 months time?

There is still a lot of uncertainty around the transfer to LAs. Structures, terms and conditions etc have not been finalised. However 72 (94%) were able to answer this question - although for some it was a best guess.

These results are broadly in line with our last survey in November 2011 but they reflect the fact that some of those saying they would not be working in UK PH last time have now left their DPH role, leaving many more Acting and Interim posts currently than in November 2011 (from 14% to 22%).

Expected future direction	November 2011			May 2012		
	Substantive DsPH = 82	Acting / Interim = 13	**Total = 95**	Substantive DsPH = 52	Acting / Interim = 20	**Total = 72**
Working as DPH in LA	53 (65%)	6 (46%)	**62%** (59)	39 (75%)	6 (30%)	**63%** (45)
Working in PH in LA (not DPH)	1 (1%)	4 (31%)	**5%** (5)	0	6 (30%)	**8%** (6)
Working in UK PH but not in LA	11 (13%)	2 (15%)	**14%** (13)	6 (12%)	3 (15%)	**13%** (9)
Not working in UK PH (inc working abroad & retired)	17 (21%)	1 (8%)	**19%** (18)	7 (13%)	5 (25%)	**17%** (12)

The figures show that **25% of substantive DsPH do not plan to transfer to LA.**

Overall, **30% of DsPH (including Acting and Interim) do not plan to transfer to LA.**

This represents a significant loss of local PH leadership and consequent risk to PH outcomes.

Taken together with the current posts covered by interim arrangements these figures show that there **could be 50-60 vacant DPH posts** to be filled. This makes support to retain current DsPH and succession planning essential and urgent.

Public Health in LA

LA Engagement

Asked how engaged their Local Authority is with their new PH role 64% (44) said their Council had a clear vision and a further 35% understood the importance of PH. Only one response said their LA was 'seeking to avoid commitment' to PH.

However, many who responded talked about the need for clarity on responsibilities, structures and transition issues before any firm commitment could be made. The problems around shrinking resource in Councils were also stated as a reason for concern for PH.

Model expected for PH in LA

Three potential models were included in the survey question and responses were evenly divided between these 3 models: separate directorate; PH as part of a broader directorate; and dispersed or integrated arrangements. However 11 (16%) of those responding to this question had not agreed a structure to date

Several responders expressed some concern that what had been decided was an interim arrangement and that there could be changes after April 2013. There was also worry that a few Councils were considering shared posts across more than 1 Council – in 1 case across 4 LAs.

The reporting level of the DPH

Of the 73 (95%) people who responded to this question only 5 said they did not know what arrangements would be in place although several others mentioned possible changes before and after April 2013.

- 66% (48) expect to report directly to the CEO or equivalent
- 10% (7) expect to report to a 'super director'
- 18% (13) expect to report to another Director (usually DASS)

The number expecting to report to the CEO has risen from 58% to 66% since our survey in November 2011 while those expecting to report to another Director remained steady (from 17% to 18%). From the comments this seems to be because there is more understanding of what PH can bring to LAs but again there was concern that structures are only temporary and restructuring was likely after April 2013 in order to save money.

In London particularly there is talk of shared DsPH across Boroughs. Of the 12 London responses, 11 answered this question: 6 expect to report to the CEO; 2 to a super Director; and 3 expect to report to another Director.

A very positive message from the survey is that 78% of those responding expect to have influence across all the Council directorates and 84% will have access to all Councillors. Many commented positively and one said that it was "up to me now" to make it work.

However, in some places - particularly where the DPH reported to another Director - the access to Members was controlled by their Director. One comment said: "I have been asked not to approach Councillors directly".

Loss of resources

We asked whether there had been a loss of PH capacity since November 2011 (our last transition survey).

- Loss of DsPH and / or Deputy or Assistant DPH = 12 (16%)
- Loss of Consultant in PH = 13 (17%)
- Loss of other Specialists = 12 (16%)
- Loss of other staff = 29 (38%)
- Loss of programme funding = 10 (13%)
- 33 (43%) did not report a loss of capacity

This is bad news especially in light of responses from the 2011 surveys which had reported loss of: DPH and/or Deputy DPH = 20; Consultants = 32; Specialists = 33.

Add this to the intended destination of current DsPH (see above) and there is a highly significant risk of vacant DPH posts after April 2013. It is, however, good to see several permanent DPH posts now being advertised which will mitigate the risk.

Public Health funding

We asked whether DsPH were broadly happy with their funding baseline: 38% said 'yes' and 34% said 'no' with 28% unsure. The specific data issues mentioned by those responding have already been highlighted in our PH funding briefings and in particular we recommend following up any shortfalls with DH who are clear that no programmes should need to be stopped and there should be no need for redundancies.

However, many DsPH flagged up the issue of historic PCT underfunding of PH being reflected in the per capita levels apportioned to them. They naturally argue for a fast rate of change to a needs based formula. **ADPH backs this policy line.** We are arguing for levelling up quickly using some of the QIPP savings that have been released by PH in PCTs.

We asked those who felt the funding was insufficient what programmes might be affected. The answers were predictably varied with: Sexual Health; Health Checks; Chlamydia Screening; obesity prevention (weight management; physical activity; diet); alcohol services; smoking cessation; mentioned several times each. Also mentioned several times were leadership capacity and indeed all non-mandated service. These are real concerns and high risk to local Public Health.

The DPH role

In February 2011 our survey found that 81% of DsPH responding agreed in principle with PH moving to LA. The same question was asked this time.

- 28% agreed it is the right place for PH;
- A further 35% agreed in principle but were worried about transition issues;
- 12% were uncertain.

This left 24% who felt that PH could do more by remaining in the NHS or being part of PHE.

There are real concerns around terms and conditions and resource but there are also worries about the future of the PH profession and succession planning. The need to clarify relationships and accountabilities and avoid duplication between LAs and PHE are also high risk issues.

Typical comments included:

"it is dangerously unclear who is responsible for what"

"links to CCGs and wider NHS need to be very strong"

Comments from some reflected the positives and opportunities offered by the move to tackle inequalities and the wider determinants.

One comment sums up several:

> "How effective a PH team is depends primarily on the calibre of the team and its leadership."

PH Teams

ADPH (along with LGA) have been arguing strongly to keep PH teams together in LAs and sharing resource across LAs for surge or more specialist capacity. Others have argued for 'local' PH professionals to be in PHE and/or CCGs or CSUs. We wanted to check with our members whether this was still their preferred option. Out of the 70 responses received for this question:

- **70% (49) agreed with ADPH's current position;**
- 10% (7) were uncertain – although mentioned the need for critical mass and form fitting function;
- 10% (7) would prefer all specialists to be employed by PHE – with several adding that they should be attached to LAs locally;
- 4% (3) wanted all PH specialists to be within CCGs / CSUs;
- Only 6% (4) wanted a combination of employers.

PH Outcomes

Finally we asked how confident DsPH are that the transition will deliver better PH outcomes for their population.

- 47% (35) were very or fairly confident given hard work and time;
- 30% (22) were uncertain;
- 10% (7) were not very confident; and
- 14% (10) were not at all confident.

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