The Association of Directors of Public Health

ADPH English System Survey 2017 - summary report

The survey was sent to all Directors of Public Health (DsPH) in England between January and March 2017 and 86 responses (68%) were received with a good spread across the regions. Of those, 78% had substantive appointments with the rest Acting, Interim or covering the role. Asked where they see themselves in 12 months, 85% said they would still be a DPH in a local authority (LA) with only 10 saying that they would not be working in an LA:

> **"best place to do pragmatic public health!"**

More worryingly six respondents said that their LA had not had a substantive DPH for more than a year and a further eight for more than six months.

The DPH role – accountability and influence

The percentage of DsPH reporting either directly to their CEO or equivalent or to a super director is down from 73% (2015 survey) to 69%. This masks a web of complex arrangements where line management does not necessarily equate to access or influence or even in some places accountability.

Of concern, only 57% are now standing members of their LA's most senior corporate management team (down from 67%). Whilst 94% said they have direct access to their CEO this is not the same in influencing terms as being round the senior table by right.

More positively, yet again there is an increase in sufficient access to Councillors (from 95%-96%) and appropriate influence across other LA directorates (from 72%-91%). 88% report having control over the Public Health (PH) budget although there appear to be more 'devolved' arrangements.

There are now 46% of DsPH taking on a wide range of additional responsibilities from animal health to bereavement services; school crossing to scientific services. Most commonly (in percentage order):

- Environmental health
- Leisure services
- Trading standards
- Community development
- Libraries/culture
- Emergency planning, response and resilience
- Licensing
- Adult social care
- Housing
- Road safety

Overwhelmingly these extra roles are regarded as positive, giving increased influence and credibility. Of course, there is a time pressure and some DsPH are concerned it detracts from the core PH responsibilities.

> **"As joint DPH/DASS my role has to be v strategic so my time and capacity to deliver PH is limited"**

> **"Complementary and enabling"**

> **"Significant in terms of time but supports PH outcomes"**

The DPH role - partnerships

We asked about relationships and received very positive messages for all except the devolution arrangements and links with NHS England (NHSE).

- 60% felt the role of PH in their Sustainability and Transformation Partnership was positive with only 12% negative
- 53% felt positive about their role in the integration process (5% negative)
- 28% felt positive about their role in devolution arrangements (9% negative)
- relationships with Clinical Commissioning Groups (CCGs) were perceived as positive by 79% (4% negative)
- relationships with Public Health England (PHE) centres were also positive (87%) (3% negative)
- relationship with NHSE were much weaker (27% positive; 15% negative) - NHSE were largely seen as distant and 'spread too thinly' to form strong links

We delved in more depth into the 'added value' of the PHE Centres and had an overwhelmingly positive reaction to their health protection work although there was still some concern over unclear responsibilities. The information and intelligence function was seen as a particular strength although inevitably some DsPH would like more support in this area. However, the health improvement work was mostly seen as duplication and led by national priorities rather than supporting local work.

On the whole, the reaction to PHE centre work was hugely variable dependant on local relationships. In several places PHE were seen as highly supportive and adding capacity to stretched local teams whilst in others they are seen as **"searching for a role"**.

We asked about access to data and 60% still feel they have insufficient access to all the data they require for their role. There have been significant improvements to access in the last year but **"there is still a lot to do"**. Particular issues are with: Secondary Uses Service (SUS) healthcare data; primary care data; more granular Screening and Immunisation data; and linkage of datasets. Mention was made of the 'tortuous' process of agreeing data sharing and the fact that not all data is available in a timely manner.

PH services and finance

There was a complex set of questions around changes and redesign of PH services. The most commonly redesigned service was sexual health with many others across the PH function being mentioned. Only 8% of responses said that the changes made had had a negative impact. It is clear that even when reducing funding for a service there is a perception that this will not harm and in most cases will enhance outcomes.

Asked about the removal of the PH grant ring-fence, 60% regarded this negatively. However, this masks a variety of reasons:

> **"the ring fence has been of little use in reality, as too weak and not meaningfully enforced"**
>
> **"the only thing that gives us some certainty and leverage"**
>
> **"depends on how LAs will be held to account for delivery of PH outcomes"**
>
> **"influencing total spend more important than merely the ring fence"**
>
> **"this creates a tremendous risk to PH and the prevention agenda"**

The introduction of Business Rates Retention (BRR) would provide both challenges and opportunities. DsPH pointed out the opportunity of better links with business and economic regeneration as well as increasing influence across all Council services using PH skills. The opportunity for place-making and the

links between the economy and health were also emphasised. Challenges were mentioned around the potential increases in inequality and loss of funding, particularly in rural areas and those with low economic growth opportunities.

There is little innovative work round this as yet although Accountable Care Organisations and asset based approaches were mentioned as potentially useful.

Mandation of PH functions is largely seen as a useful lever. We received 85 responses (table below) to the question: 'Of the currently mandated functions below, how would you like to see them changed in the future?'

Answer Options	Same as currently	More detailed	Less detailed	No mandation
Weighing and measuring of children (The National Child Measurement Programme)	51	7	8	19
NHS Health Check assessments	31	4	13	37
Sexual Health services	51	23	9	2
0-5 public health services (including health visitors)	43	19	20	3
Public health advice service (to CCGs)	39	19	13	14
Health protection	52	30	1	2

Health Checks stands out as having far less support from DsPH with Health Protection and Sexual Health receiving the most positive support for mandation. Overwhelmingly the candidate for any further mandation was seen as Drugs and Alcohol services but mandation is by no means seen as the 'solution':

"not sure what mandation adds, may do more detracting from areas that aren't mandated"

PH training and support

We asked a series of questions around the pathway to becoming a DPH. Specialist training was not seen as providing sufficient context for work in local authorities and for working with reduced funding although the recent curriculum changes were regarded as very positive. There was praise for the Aspirant DPH programme (which is continuing) but a recognition that there should be an earlier and stronger focus on leadership skills for all.

Asked how we could promote the DPH role more there was a view that there should be more exposure to DPH responsibilities (e.g. by recognition of a formal Deputy role) but concern around the pay differential between the DPH and Consultant roles.

Conclusions

There is a lot more detail in the survey responses which ADPH will use in tailoring its offer to members and in its system partnership work, discussing particular areas in more detail with relevant partners. We are also recommending the following.

- Continue to monitor DPH numbers and in particular long-term interim and acting roles.
- Support for the pathway to becoming a DPH in a variety of ways including: further exposure to the DPH role for Consultants; supporting the 'newly and nearly' DPH; promoting the positive.
- Support for those DPH taking on wider functions in local authorities and promoting the positives in this arrangement.
- Work to improve links with NHS nationally and locally.
- Continuing to work with NHS Digital, PHE etc. to ease access to data for DsPH and their teams.
- Continue to work with PHE, DH etc. to seek sensible arrangements post-ringfence and for BRR.