The Association of Directors of Public Health

ADPH System Survey 2019 Summary Report

Introduction

This summer, we conducted a survey of Directors of Public Health (DsPH) in the UK to gather their thoughts and experiences on a range of challenges and opportunities facing public health.

The survey was open throughout June and July to full members, including DsPH from the devolved nations. A total of 99 responses were received, the vast majority from England (representing 72% of English members). We were pleased to receive some input from the devolved nations and have highlighted responses that include their feedback.

Key findings

DPH Role

- 74% of respondents had substantive appointments (78% in 2017). There were 20% of respondents in an Interim or Acting role. Six said that their LA had not had a substantive DPH for more than a year and a further seven for more than six months, which is unchanged from 2017. 6% responded 'Other' due to differing local arrangements.*
- Asked where they see themselves in 12 months, 80% said they would still be a DPH locally (85% in 2017) with only three saying that they would remain working within Public Health but not locally.*
- Falling trend of DsPH reporting either directly to their CEO or equivalent or to a super director. This year it was 67%, down from 69% in 2017, and 73% in 2015. However, this masks a web of complex arrangements where line management does not necessarily reflect access, influence or accountability.
- An increasing number of DsPH are taking on additional responsibilities. 53% manage other council services like adult social care, community development and leisure. Despite the time pressure, these extra roles are overwhelmingly regarded as positive, offering increased influence and credibility.

Access to data

- Just 55% of DsPH said they had sufficient access to data, down from 60% in 2017. Ongoing issues with access to NHS data, insufficient data sharing agreements and delays in intelligence sharing were highlighted as particular barriers.

Influence

- DsPH have healthy and increasing levels of influence within local authorities. 97% said they had direct access to their CEO (up from 94% in 2017) and 99% said they had sufficient access to councillors. A greater number of DsPH reported having day-to-day control of the public health budget (96% from 88% in 2017). This likely reflects new arrangements strengthening the role of DsPH in signing off public health budgets.

  "I have control of most of the public health grant, although approximately 22% is earmarked for 'wider determinants' work. I am working on my influence on this section of the budget."

*Includes responses from devolved nations

- While the number of DsPH who said they were a standing member of their LA's most senior corporate management team (CMT) increased slightly (60% from 57% in 2017), it is still low, particularly in comparison to other influencing measures.

Relationships

- DsPH have varying levels of satisfaction with key partners in the system. Their most positive relationships are within Local Authorities, with Directors of Adults Social Services (99% positive), Directors of Children's Services (89% positive) and relationships with other LA directorates (88% positive).
- Relationships with CCGs are improving: 83% felt positive about it, an increase from 2017 (79%). However, relationships with NHSE continue to be weak – just 27% felt positive about it (no change from 2017) and a greater proportion felt negative (26% from 15% in 2017).
- Feelings aren't as strong for the role of PH in their local ICS process (68% positive) and local integration process (65% positive). However, these are an increase from 2017, when 60% felt positive about the role of PH in STPs, and 53% felt positive about their role in the integration process.
- Relationships with PHE Centres show a significant drop – 76% felt positive about it, compared to 87% in 2017. Comments about the added value of PHE Centres echoed those of the 2017 survey. Relationships with Centres are hugely variable and dependent on local relationships. Issues mentioned continue to be around duplication of work, an imbalance between local and national jurisdiction, and a lack of understanding from PHE Centres of the local government context.
- Health Protection continued to be the most valued service provided by PHE Centres, closely followed by Knowledge & Intelligence services. Advice and support, including opportunities for professional development were also valued.

Funding

- With respect to the impact of cuts locally to service, the most commonly redesigned service in the last three years was sexual health services. Less than 2% of those that had redesigned their service reported that the change had a negative impact. The other most commonly redesigned services were health visiting and school nursing.
- Public health advice within councils was the most common function to have increased in provision over the last three years. Looking ahead, the services most commonly reported to be undergoing redesign over the next three years were health visiting and school nursing.
- 56% negatively regarded the removal of the PH grant ring-fence. This masked a variety of reasons including concern that it could lead to further cuts as funding would be diverted to other competing priorities, and concern that funding may not be made available beyond the spend for statutory services. The impact would largely depend on the status of public health locally. Feelings towards the removal of the ring fence were also largely dependent on whether appropriate assurances (e.g. minimum spend on public health) and monitoring will be in place.
- With the introduction of Business Rates Retention (BRR), opportunities DsPH highlighted included the potential for greater local flexibility and the potential to influence the wider Council budget and introduce a health in all policies approach within LAs. The main challenges reported, were around the potential for further cuts to public health funding, as well as the potential widening of inequalities.

*Includes responses from devolved nations.

"Opportunity to reprioritise our spend towards prevention as we shift to stronger local decision making.''

"Opportunity to build ownership in the authority for health improvement.''

Public Health Mandation

- DsPH were asked how they would like to see currently mandated functions changed in the future. Notably, Heath Checks had the least support from DsPH for continued mandation, with 54% of respondents saying they wanted to see no mandation of the function.
- Health Protection, Sexual Health and 0-5 public health services received positive support for mandation to either stay the same or become more detailed.

	Same as currently	No mandation	More detailed	Less detailed
Weighing and measuring of children (NCMP)	62.8%	26.9%	1.3%	9.0%
NHS Health Check assessments	26.9%	53.8%	5.1%	14.1%
Sexual Health services	65.4%	7.7%	21.8%	5.1%
0-5 public health services (including health visitors)	61.5%	6.4%	16.7%	15.4%
Public health advice service (to CCGs)	38.5%	30.8%	20.4%	10.2%
Health protection	59.0%	5.1%	30.7%	5.1%

Spending Review*

- With the Spending Review due to take place next year, DsPH were asked what their priorities for investment were, aside from public health. Nationally, poverty, early years, and education and skills were the top three priorities for DsPH. Early years, social care and housing emerged as the top three priorities locally.

Policy *

- Policies that received high levels of support from respondents included:
    - introducing a child poverty strategy with binding national targets to reduce child poverty (86% supported)
    - reducing promotions of foods that are high in fat, sugar and salt (85% supported)
    - introducing of a minimum price of 50p per unit of alcohol (83% supported)
    - prioritising active travel in transport policy and continued investment in infrastructure for active travel (81% supported)
    - amending licensing legislation to empower local authorities to control the total availability of alcohol, gambling, junk food outlets (80% supported)
    - implementing a tax or levy on tobacco manufacturers to help cover the cost of smoking to the NHS and wider society (73% supported)
- Increasingly DsPH support the use of vaping as an aid to quit smoking with 75% of respondents supporting the use of e-cigarettes in smoking cessation services.
- DsPH were asked what other policies they thought were needed to promote longer, healthier lives. Key themes that emerged from responses were the adoption of a health in all policies approach; move towards a budget for wellbeing; focus on population level policies which address the root causes of poor health and tackle health inequalities.

*Includes responses from devolved nations.

Recommendations

There is a lot more detail in the survey responses which ADPH will use to both tailor our offer to members and inform our policy and influencing work. We also make the following recommendations and commitments:

- Continue developing support for DsPH with expanded portfolios, to include facilitating networking with colleagues with similar portfolios and sharing good practice about matrix working.
- Improve access to data and data sharing. ADPH will continue to work with partners including the NHS to ease pathways and develop processes that support improved and timely data sharing.
- DsPH, as frontline leaders of public health should have a place at top level discussions and decision making. We will keep building and promoting strong relationships across the NHS, local government, public health, and voluntary and community sector to facilitate this.
- Increased local investment in early years, social care and housing. ADPH will work more closely with key partners, including our counterparts in adult social care and children's services - to make a stronger case collectively for this.
- Prioritise national investment in early years, education and skills and tackling poverty. We will focus influencing work on making the case and engage with key stakeholders to support this call.
- Introduce key public health policies supported by DsPH including binding national targets to reduce child poverty, introduction of a 50p minimum unit price for alcohol and taxing tobacco manufacturers to help cover the cost of smoking to the NHS and wider society. Further information about these and other public health topics can be found in ADPH's policy positions.
- Continue to promote a health in all policies approach whether from within local authorities, the NHS or across other public health services.
- Concerted action to address the wider determinants of health and a move towards building wellbeing into the fabric of Government decision making – both in terms of policy development and funding allocation.

Additionally, in England:

- Work with PHE and PHE Centres in England to foster stronger and more productive working relationships, understanding of the local government context and avoid duplication of work.
- Continue to work to improve links with NHS nationally and locally.
- Engage with Directors Public Health on BRR reform in England to ensure that appropriate assurances are put in place to support local authorities carry out their duty to improve and protect population health.

*Includes responses from devolved nations.