Learning the lessons from the transfer of public health to councils

An independent review of the impact of the transfer in county areas

February 2019

Executive Summary

Local authorities "will create a 21st century public health system based on localism, democratic accountability and evidence." The then Department for Health's aspirations for the transfer of public health to local government in 2013 mirror the current Secretary of State's commitment to prevention in which he envisages local councils "taking the lead in improving health locally through innovation, communication and community outreach."

The County Councils Network (CCN) commissioned Shared Intelligence (Si) to review the impact of the transfer in county areas. The core evidence for this report is a series of semi-structured, non-attributable interviews with directors of public health (DPH) and other local stakeholders in 14 county areas.

Our local authority interviewees were positive about the impact of the transfer. They paint a picture in which public health teams are working across the full range of council functions to improve health and wellbeing by mobilising the wider determinants of health. They report that councillors are acting as powerful advocates for public health and that local authority commissioning and procurement expertise is benefiting commissioned services.

Health stakeholders are less positive about the impact of the transfer. They point to the consequences of reductions in council resources and a growing gulf between their organisations and public health teams in local councils.

On the basis of this research we have identified four factors which can act as drivers of, or barriers to, an effective public health function in local government. They are:

- The position of public health in the local council - whether or not the DPH reports directly to the chief executive matters;

- The relationship with district councils in two tier areas: in some places public health is acting as catalyst for improved relations; in other places poor relations are undermining efforts to mobilise the wider determinants of health; ;

- Devoting time and capacity to developing and maintaining links with health commissioners and providers;

- Geography: coterminosity, or even a degree of it, helps.

This research suggests that county authorities are well placed to play a key role in driving preventative activity as envisaged in The NHS Long Term Plan. We recommend that CCN should support and share learning between its members to ensure that the factors identified above act as enablers of an effective public health function rather than as barriers to it. We also recommend that there should be substantive discussions between local government and the health service at both a national and local level to reboot the relationship between public health in local councils and health providers and commissioners.

1   Introduction

1.1   On 1 April 2013 responsibility for public health was returned to local authorities almost four decades after the NHS took over most public health functions. The government said that its vision was "for local authorities to use their new responsibilities and resources to put health and wellbeing at the heart of everything they do, thereby helping people to lead healthier lives, both mentally and physically."[1]

1.2   Since the transfer back to local government there has been an on-going debate on the success or otherwise of the move.

1.3   Proponents of the changes argue that reform has brought local democratic leadership to public health, with a wider remit for councils to marshal the wider determinants of health to improve the wellbeing of the people and communities they serve. Supporters also suggest that the transfer brought greater financial discipline and expertise to the commissioning of public health services.

1.4   Others, particularly those in the health service, are critical of the impact, with some of them seeing it as a mistake. Many have cited the effects of the reductions of the Department of Health (DoH) public health grant, the wider impact of "austerity" on council services, and fragmentation of commissioning responsibility. Some argue that since the transfer the status of public health has been downgraded, while its relationship with the NHS has suffered. Many people acknowledge, however, that public health budgets were cut while it was within the NHS and that its profile then was not particularly high.

1.5   In light of this on-going debate and at a time when the future of health and social care services are in the national spotlight, the County Councils Network (CCN) commissioned Shared Intelligence (Si) to review the impact of the transfer of responsibility for public health in county areas through a series of non-attributable interviews with key stakeholders.

1.6   The completion of this report coincided with the publication of The NHS Long Term Plan and the government is committed to publishing a social care green paper before the end of the 2018-19 financial year. By reviewing the impact of the transfer of public health in county areas this research is intended to inform local government's response to the Long Term Plan and in particular the ambition to secure the best possible join up between the NHS and local government on public health.

1.7   The review has specifically explored;

- the impact of the transfer on the "core" public health functions;
- the wider contribution of public health to local government as a result of the transfer;
- implications for the relationship between public health and the NHS nationally and locally;

[1] Local government leading for public health (Department of Health, December 2011)

- aspects relating to the wider context including devolution and the increasing focus on place-making.

1.8 The core evidence for our research is a series of semi-structured non-attributable interviews in 14 county areas. We interviewed the Director of Public Health (DPH) in all 14 areas. In four areas we interviewed three other people and in the other areas we spoke to one other person. The other interviewees included chief executives, chairs of health and wellbeing boards, accountable officers of clinical commissioning groups (CCGs) and the chief executives of health providers. We also interviewed a small number of national stakeholders.

1.9 To inform the key lines of inquiry for this research we reviewed the findings of four significant pieces of research[2] on the impact of the transfer. We have also drawn on the themes arising from a collection of case studies[3] recently published by the Local Government Association (LGA)

1.10 Separately, CCN recently commissioned LG Futures to undertake an analysis of public health funding since the transfer in 2013. For contextual purposes, this report includes some of these findings.

1.11 Our report begins by summarising the objectives underpinning the transfer and the specific county context in which the transfer has taken place. Based on our interviews, we then outline the key findings and how this relates to existing research on the public health transfer. Finally, we identify and describe a set of factors which, on the basis of this research, we conclude are the drivers of and barriers to the effectiveness of the public health function in county authorities.

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[2]Gadsby et al 2017, *Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed?* BMC Public Health. Jenkins et al 2016, *Integration, influence and change in public health: findings from a survey of Directors of Public Health in England*, Journal of public health. Willmott at al 2015, *Making the case for investment in public health: experience of Directors of Public Health in English local government*, Journal of Public Health. Llinos Mary Jehu et al 2017, *Directors of public health as 'a protected species': qualitative study of the changing role of public health professionals in England following the 2013 reforms,* Journal of Public Health.

[3] Public health transformation five years on: Transformation in action (LGA, 2018)

2 Public Health & Local Government

2.1 In analysing the transfer of public health in counties, it is crucial to understand the motivations behind the transfer and the on-going policy context impacting the sector. This provides a platform for the remainder of this report to explore the extent to which the arrangements the government envisaged have been put in place and whether they are contributing to improvements in health and wellbeing.

The Transfer: Health & Social Care Act 2012

2.2 On 27 March 2012, The Health and Social Care Act 2012 received Royal Assent. This wide-ranging Act abolished Primary Care Trusts (PCTs) and Strategic Health Authorities, with NHS planning and delivery functions transferred to the NHS Commissioning Board and Local Clinical Commissioning Groups (CCGs).

2.3 Before 2013 local public heath teams were located in PCTs. The Act included an overhaul of PCT public health functions, with responsibility returned to local authorities almost four decades after the NHS took over most public health functions. The national agency Public Health England (PHE) was also established. PHE took on the role of the Health Protection Agency, the National Treatment Agency for Substance Misuse and a number of other health bodies, with its remit to work with local authorities to protect and improve the nation's health and to address inequalities.

2.4 Supported by a ring-fenced grant and a statutory duty to 'take steps to improve the health of their population', upper-tier councils were tasked with re-integrating a range of public health functions back into local government, including statutory functions for health protection and improvement.

2.5 From April 2013, upper tier councils were responsible for appointing a Director of Public Health (DPH), establishing a Health and Wellbeing Board (HWB) and commissioning Local Healthwatch. Government set out in statutory guidance that the membership of Health and Wellbeing Boards must consist of specific elected members and local authority directors, CCG chairs, and locally decided appointments.

2.6 Health and Wellbeing Boards are required to carry out a Joint Strategic Needs Assessment (JSNA), publish a local Health and Wellbeing Strategy and review CCG commissioning plans to ensure they reflect the needs and priorities of these documents.

2.7 Later in October 2015, responsibility for public health services for children aged under 5 were also transferred to local authorities.

2.8 Within this new framework, Government statements making the case for the transfer envisaged that "local leadership for public health would be at the heart of the new public health system."[4]

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[4] The new public health role of local authorities (Department for Health, October 2012)

2.9   At a political level, the then Secretary of State for Health stated that local elected members would improve "local accountability and reward the progress that communities make".[5] Guidance issued in 2012 ahead of the transfer outlined that cabinet members given public health responsibilities would be directly responsible for new duties relating to 'health improvement' and providing "the appropriate political leadership at the local level". This included ensuring that new duties on health improvement complemented the local authority's existing core business, and its strategic responsibility for stewardship of place.[6]

2.10   The DoH statement issued in 2012 also went into some detail on the government's expectations of the role of the director of public health. They would, it said, "champion health across the whole of the local authority's business, promoting heathier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed."

2.11   The statement went on to say that the government envisaged that the DPH would "be an important official within the authority, influencing decisions across the range of the authority's business." To deliver this role, it argued, "we would expect there to be direct accountability between the DPH and local authority chief executive (or other head of paid service) for the exercise of the local authority's public health functions, and that they will have direct access to elected members."

Prevention & the Wider Determinants

2.12   Much of the case for the transfer of public health back to its historic home of local government was based on the greater prioritisation that could be given to prevention and tackling the 'wider determinants' on health.

2.13   According to the then Secretary of State, the leadership provided by local authorities working together with their public health partners, through the critical role of the DPH, the new system would have "the resources and the authority to make preventative interventions to improve the health of their communities".[7]

2.14   Drawing on the influential work of Sir Michael Marmot, the wider service remit of councils would therefore be used to tackle the root causes of ill health, rather than simply treating the consequences of its development. Tackling the conditions determining people's health outcomes were believed to require action, across the life-course, well beyond the influence of the NHS and traditional public health services such as smoking cessation and sexual health. Local government's role in promoting physical activity, environmental protection, planning, housing and economic development were seen as critical to the new system.

2.15   Key to pushing forward a preventative agenda that focused on the wider determinants was ensuring that public health services were not simply bolted onto the side of the council but were genuinely integrated within the organisation.

2.16   According to the Government, local authorities should: "embed their new public health functions into all their activities, tailoring local solutions to local problems, and using all the levers at their

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[5] The new public health role of local authorities (Department for Health, October 2012)
[6] Ibid
[7] HSJ, July 2017 https://www.hsj.co.uk/leader/the-vision-for-public-health-dims-as-confusion-surrounds-spending/5032831.article

disposal to improve health and reduce inequalities. They will create a 21st century public health system based on localism, democratic accountability and evidence."

2.17   The Department of Health identified six ways in which councils would deliver their public health responsibilities underpinned by "a willingness to use all the tools at local authorities' disposal in a new way and not just rely on commissioning traditional services." The six forms of action that would advance the preventative agenda were:

- Including health in all policies so each council decision seeks the most health benefit;

- Investing the ring-fenced grant in high quality public health services;

- Encouraging health promoting environments;

- Supporting local communities, promoting community renewal and engagement;

- Tailoring services to individual needs based on a holistic approach rather than single issue services;

- Making the most effective use of resources in terms of value for money and targeting areas and groups in most need.

Financial Environment

2.18   The backdrop for the transfer, as with all local authority service since 2010, has been the impact of austerity. Despite the transfer being accompanied by a 'ring-fenced grant', public health did not escape funding reductions.

2.19   According to an analysis undertaken for CCN by LG Futures,[8] the level of public health grant for local authorities peaked in 2015/16 at £3.46bn, with the transfer of children's 0-5 services. It has subsequently fallen year on year to an indicative £3.13bn in 2019/20. For counties, public health grant peaked in 2016/17 at £1.186bn and fell to 1.072bn in 2019/20.

2.20   In 2015/16, local authority allocations for public health were initially frozen at their 2014/15 levels, with each authority's allocation subsequently scaled down at a uniform rate to achieve in-year savings of £200m. From 2016/17 to 2019/20, each authority's public health grant was reduced at a uniform rate from the previous year. Overall, current spending plans suggest that there will be a £0.7bn real terms reduction in the public health grant between 2014/15 and 2019/20.[9]

2.21   It is important to note that counties are the lowest funded type of local authority for public health services, receiving 34.2% of overall funding. Under the current formula CCN members' allocations are £42 per head, compared to a national average of £57. This compares to £71 per head for Metropolitan Boroughs, and £102 per head in Inner London Boroughs.[10] Under a proposed new formula expected to be implemented in 2020/21, counties would continue to be assessed to have 'needs per head' at 28% below the national average, compared to 39% above the average in Metropolitan Boroughs and 39% above in Inner London.

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[8] LG Futures for CCN (2018) (Unpublished)
[9] https://www.health.org.uk/sites/default/files/upload/publications/2018/Taking%20our%20health%20for%20granted_for%20web.pdf
[10] LG Futures for CCN (2018) (Unpublished)

3   Lessons from the Transfer

3.1   Debate on the effectiveness of the transfer of public health services to local government, and specifically counties, has taken place since arrangements began to bed in over the past few years. Within this debate there are significant differences of view between people in local government and the health service. There are also differences in perspective within the public health community which are encapsulated in the two quotes below.

"We spent all our time saying it wouldn't work. Five years down the line it's been the best thing for public health and for local communities and residents."

Director of Public Health

"It was the right reform, but it was introduced at the wrong time."

National stakeholder

3.2   It is clear from discussions with local authority interviewees that they are broadly positive about the impact of the transfer. They paint a picture in which many public health teams are working across the full range of council functions to improve health and wellbeing. They report that councillors are acting as powerful advocates for public health and that local authority commissioning and procurement expertise is benefiting commissioned services. There is a spectrum of opinion about the impact of this on the wider determinants of health.

3.3   The positive picture of the impact of the transfer of public health emerging from our interviews is reinforced by the evidence of public health outcomes, presented below, which shows broad across a number of health outcomes.

3.4   However, many of the people we interviewed in the NHS, particularly in CCGs, are critical of the impact, with some of them seeing it as a mistake. Everybody we spoke to referred to government reductions in the public health grant and the wider impact of "austerity". The implications of this for efforts to mobilise the wider benefits of the location of public health in local government have varied from place to place.

3.5   From our research, it is possible to identify several factors which can aid an understanding of the impact of the transfer. They are the:

- Level of **awareness** and understanding of public health services within councils;

- Degree of **influence** over other policy and service areas;

- Enhancements to **commissioning and procurement;**

- Improvements to **evidence-based** policy development;

- How the specific **county dimension** has been approached;

- Interaction with **health partners** locally and nationally.

3.6   These factors influenced the drivers and barriers to effectiveness of the transfer in county areas, which the next chapter considers. This section draws primarily on the non-attributable interviews that form the core of the evidence base for this report. The synthesis of the interviews is supplemented where appropriate by other evidence and relevant literature.

Awareness

> "Before the transfer most councillors didn't know what public health was. Members now think about it far more."

Public health portfolio holder

3.7   All of our interviewees were clear that local councils now have a far better understanding of public health and the contribution that different services can make to health outcomes. Many DsPH and their colleagues were wary of the role of local politicians, but most of the directors we interviewed now see councillors as some of the best advocates for public health. They stress the value of portfolio holders in influencing other members of the cabinet and the key relationship between all councillors and the communities they represent. This is seen as being particularly valuable in supporting action to mobilise the power of communities to improve health and well-being.

> "We need to build on this and make better use of councillors as advocates in their communities."

Director of public health

Influence over policy and service areas

3.8   In its 2011 publication the DoH referred to the potential of local authorities to act to improve public health through the following functions: housing, economic and environmental regeneration, strategic planning, education, children and young people, fire and road safety. Between them our interviewees have pointed to successful action in all of these areas.

> "A director of public health is far more influential from within a council."

Director of public health

> "It has not revolutionised things, but it brings a closeness that wasn't there before."

Director of Public Health

3.9   Most of our interviewees reported that their councils are beginning to influence the wider determinants of health in order to improve the health and wellbeing of their communities they serve. They are achieving this through collaboration with other county functions and, where appropriate, by working with district and borough councils.

3.10 Examples of the sorts of activities that are being pursue include:

- Action on air quality;

- Cycling and walking strategies, the promotion of physical activity and other active travel initiatives;

- The role of the planning system in creating healthy communities;

- Joint work with district and borough councils in topics such as fuel poverty and homelessness;

- Collaboration with children's services including as part of an improvement programme;

- Developing approaches to inclusive economic growth in deprived communities.

3.11 In terms of the place agenda DsPH talk about working with their colleagues on issues ranging from air quality and 20mph zones to active transport campaigns and the incorporation of heath criteria in planning policies and guidance. Public health teams are driving integrated work on homelessness and they are collaborating with trading standards and regulatory services.

3.12 In some places the public health team is at the forefront of discussions about how to empower communities to play a bigger part in action to improve health and wellbeing while reducing dependency on the state. There is also a widespread view that councillors and officers now have a far better understanding of the role and contribution of public health, its contribution to place-making and the potential impact of action on the wider determinants of health.

3.13 Several DsPH referred to collaboration with children's services including in one case contributing to a post-OFSTED improvement programme. Work with schools on mental health is a priority in a number of areas, as is involvement with wider employment, skills and inclusive growth strategies.

"Public health has a high profile in the county council...They were the forgotten corner of the NHS"

County chief executive

3.14 The literature review undertaken supports the positive picture painted by our interviewees on the integration of services within local government. Earlier research shows that many DsPH had been fearful of a loss of influence as a result of the transfer, but in practice they have found that they are having an impact on the wider determinants of health and are well-placed to influence other areas of local authority activity. The research showed that many DsPH who report directly to the chief executive feel particularly well-placed to maximise the public health role. Some concerns were identified in the research about a decline in influence over clinical commissioning groups.

3.15 Reflecting on its most recent case studies the LGA concludes that the councils concerned were "fully embracing public heath's location at the heart of local government to influence the functions that impact on health". The association concludes that DsPH feel that they are pushing at an open door within local government and "to a lesser extent" within the NHS when they prioritise prevention.

This mirrors the emerging concern within our research, outlined below, about the traction of public health in local government back into the NHS.

Evidence

3.16   A significant strength of the public health teams is their use of evidence to support the design, implementation and evaluation of interventions. The JSNAs are a prime example of this capacity. Several interviewees report that their councils have benefitted from the transfer by bringing the evidence-based nature of public health into the authority.

> "We have brought science into the local authority...that understanding of data and intelligence."

Director of public health

3.17   Our interviews suggested that the transfer had facilitated a strengthened use of evidence, in particular service areas such as adult social care. In others it has influenced the use of evidence across the council, with public health analysts embedded in corporate intelligence teams. In some places this has enabled the council to re-build a capacity that had shrunk in the current financial climate.

> "Good evidence can change minds and attitudes."

Public health portfolio holder

Commissioning and procurement

> "We have strong procurement support that simply wasn't there in the NHS."

Director of Public Health

3.18   Alongside a more robust evidence-based policy approach, exposure to local government's commissioning and procurement expertise is seen by many DsPH as an unanticipated benefit of the transfer. There is a widespread view from our interviews that it is more robust than equivalent processes in the NHS and that public health teams have learnt an enormous amount. This expertise is seen as having been critically important in responding to reduced resources and in decommissioning existing services, making them more community-oriented and empowering communities to do more for themselves. It has resulted in a shift away from traditional commissioning models and enabled more flexibility in integrating services. Interviewees also welcome what they see as a reduction in micro management. Even sceptics in the NHS see access to this aspect of local government capacity as an advantage for public health.

3.19   A financial analysis of public health expenditure carried out for CCN by LG Futures illustrates the impact of council commissioning and procurement. On average in CCN member council areas the largest areas of public health expenditure are on children aged 0-5 (28.2% of expenditure), substance misuse (20.7%) and sexual health (17.1%). These are broadly in line with national trends, with the exception of London authorities who on average spend a larger proportion of their public health grant on the provision of sexual health services.

3.20   The financial analysis shows that since the transfer there have been significant changes in the composition of expenditure on services, as illustrated in the chart below. From 2013/14, the services experiencing the largest reductions in spending were substance misuse (-£26.5m), smoking & tobacco (-£22.3m) and sexual health services (-£20.7m). This was offset by increases in children 5-19 (£9.2m), physical activity (£8.7m), other public health services (£7.1m) and miscellaneous[11] expenditure (£44.1m). Spending in these two latter categories are widely seen as reprioritising public health expenditure to tackle the wider determinants of health and public health teams making better use of the public health budget. As shown below, outcomes for both sexual health and smoking prevalence have improved in county areas despite the fall in spending on these services.

Expenditure in county areas
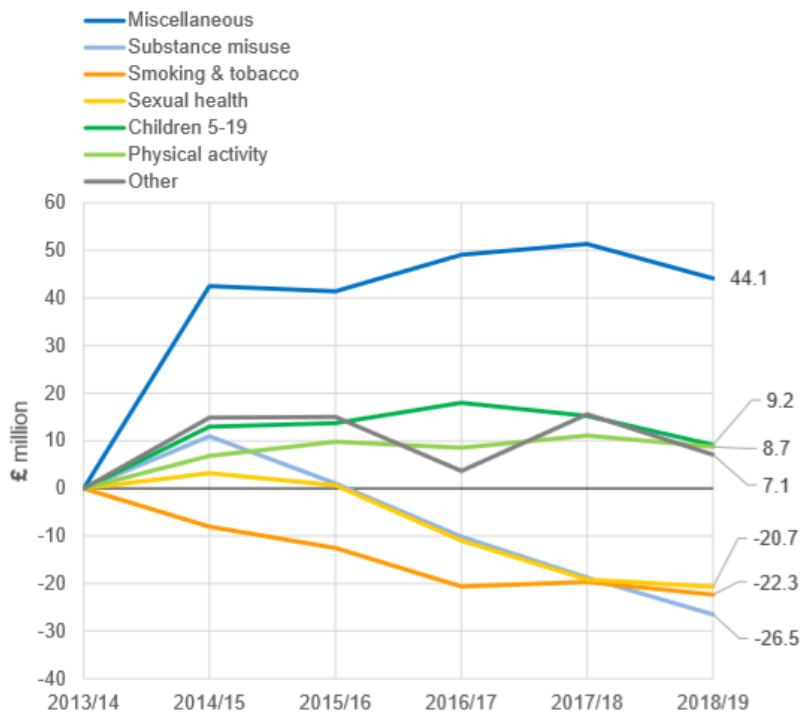
> "The impact of the cuts has been counter-balanced by more innovative commissioning."

NHS provider trust chief executive

3.21   More robust commissioning, procurement and project management is one of the factors that has affected the relationship between public heath teams and health and care providers. In many cases, according to our interviewees, it has led to the relationship being more formal and structured. One

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[11] This corresponds to the 'Miscellaneous public health services – other' category. It is not disaggregated further in the RA or RO forms.

interviewee added that, if the relationship is to develop further, it will be important for councils to learn more about how other organisations commission services.

"Financial stringency has generated innovation in discussions with providers."

Director of public health

3.22   The previous research explored as part of our literature review highlights the impact on public health of local government's more robust approach to commissioning and procurement with its focus on best value, the scrutiny of performance and outcomes data. This is also a theme in the LGA report which notes: "Many DsPH have commented that local government's expertise in procurement and monitoring of contracts has provided a learning curve for them and that they have welcomed the chance to shape commissioning".

Has the transfer improved outcomes?

The positive picture of the impact of the transfer of public health emerging from our interviews is reinforced by the evidence of public health outcomes. CCN's analysis of PHE data shows that in county areas:

- Healthy life expectancy for males increased from 64.8 years in 2013-15 to 65 years in 2014-16, compared with 61.8 and 61.9 years nationally;

- Healthy life expectancy for females has remained static at 65.8 years over the same period, compared with 62.1 and 62.3 per cent nationally;

- Between 2012 and 2017, the rate of diagnoses for new STIs (excluding chlamydia in under 25 year olds) in county councils in England fell from 620 per 100,000 population to 560 per 100,000 population.

- Between 2012 and 2017, the prevalence of smoking among adults in county councils in England fell from 18.0% to 13.9%.

- The cumulative percent of the eligible population aged 40-74 offered an NHS health check who received an NHS health check has increased in CCN member council areas from 43.87 per cent in 2013/14 to 47.82 per cent in 2017/18.

The LGA recently published a more comprehensive analysis of data from Public Health England spend and outcome tool. This demonstrated that a number of key health outcomes have improved since responsibility for public health transferred to local authorities, despite the spend in several areas falling, primarily due to government reductions to local authority budgets. Improved outcomes include reducing premature deaths, reducing new cases of sexually transmitted infections and a reduction in adult smoking prevalence. Other public health challenges have increased, however, including childhood obesity and the prevalence of depression.[12]

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[12] LGA. Improving the public's health Local government delivers (2019)
https://www.local.gov.uk/sites/default/files/documents/1%2088_LGA_Improving%20the%20publics%20health%20local%20government%20delivers_February%202019.pdf

PUBLIC HEALTH TRANSFER

Assessing the impact in counties

Eligible people who received an NHS health check has increased in counties from 43.8% in 2013 to 47.8% in 2018

Nationally: 49.3% in 2013 to 48.3% in 2018

Since 2013, number of active smokers has decreased from 17% to 13.9%

Nationally: Decrease from 18.1% to 14.1%

Healthy life expectancy for males increased from 64.8 years in 2013 to 65 years in 2016

Nationally: Increase from 61.8 years in 2013 to 61.9 years in 2016

Between 2012- 2017, the rate of diagnoses for new STIs (excluding chlamydia in under 25 year olds) in county areas fell from 620 per 100,000 people to 560 per 100,000

CCN
COUNTY COUNCILS NETWORK

A FAIRER FUTURE FOR COUNTIES
COUNTY COUNCILS NETWORK

County dimension

3.23   We asked our interviewees what they thought was distinctive about the transfer of public health to counties. In exploring this aspect it is important to understand the geographic and population make up of counties which has specific implications for their public health needs and the approach to tackling the wider determinants of health.

3.24   Healthy life expectancy for both males and females is higher in county areas compared to other types of local authorities and in areas such as smoking, the prevalence amongst adults is lower.

3.25   The rural nature of counties adds a distinctive dimension to action to tackle the wider determinants of health. Rurality and sparsity present specific challenges for the delivery of services such as public health. Government guidance from DEFRA highlights that delivering services in rural areas presents challenges for the following reasons:[13]

- **Demographics:** There are proportionately more elderly people and fewer younger people in rural populations compared with urban ones.
- **Access to services:** The combination of distance, transport links and low population density in rural areas can lead to challenges in accessing and providing services.
- **Service infrastructure:** Lower levels of infrastructure such as low broadband speeds and variable mobile coverage can be a barrier for rural businesses and limit the growth in rural productivity.
- **Employment**: The variety of employment opportunities, the availability of people with the right skills, and access to training can be lower in rural areas.

3.26   Most of our interviewees pointed to the larger size and scale of CCN's members. The new public health arrangements implemented from 2013 onwards in counties covered significantly larger populations and geographies.

3.27   The average HWB in a county council area spans a geographical area measuring 262,331 hectares, and county unitary board spans 240,649 hectares. This compares to an England average of just 20,795 hectares. Population density in the average county council measures 3.1 persons per hectare compared to an English average of 6.1, 19.56 in Metropolitan boroughs and 63.5 in London.

3.28   Covering such large areas, CCN has previously highlighted the complexity of health partnerships working across its membership, with over 60 acute trusts and approximately 80 CCGs operating in their localities.[14]

3.29   The scale of public health budgets is significantly larger, as the scale of services commissioned by county authorities. In 2018/19, the CCN authorities are budgeted to spend £1.139bn on public health, which is 34.4% of the England total.[15] The most recent data shows that the average county council commissioned 33,439 NHS health check appointments over the past 12 months, compared to a council average of 12,231.[16]

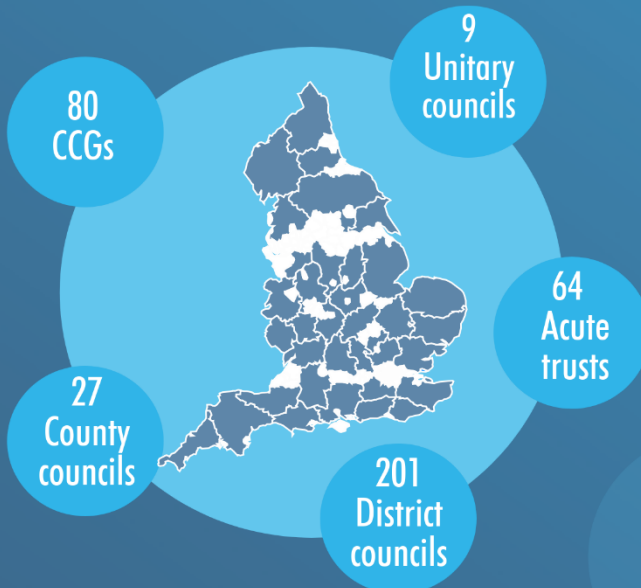[13] Rural proofing Practical guidance to assess impacts of policies on rural areas (March,2017)
[14] https://www.countycouncilsnetwork.org.uk/download/1012/
[15] LG Futures for CCN (2018)
[16] LG Inform, NHS Health Checks data set.

PUBLIC HEALTH TRANSFER

Understanding county size and scale

80 CCGs

9 Unitary councils

27 County councils

64 Acute trusts

201 District councils

COMPLEX HEALTH ECONOMIES

The public health transfer in counties means that services now cover larger and more complex geographies

The average county council Health and Wellbeing Boad covers a geographical area measuring 262,331 hectares on average

In contrast, the average non-county authority's Health and Wellbeing Board covers a geographical area measuring 20,795 hectares

The amount counties budgeted to spend on public health in 2018/19:

£1.139bn

34.4% Of England's total

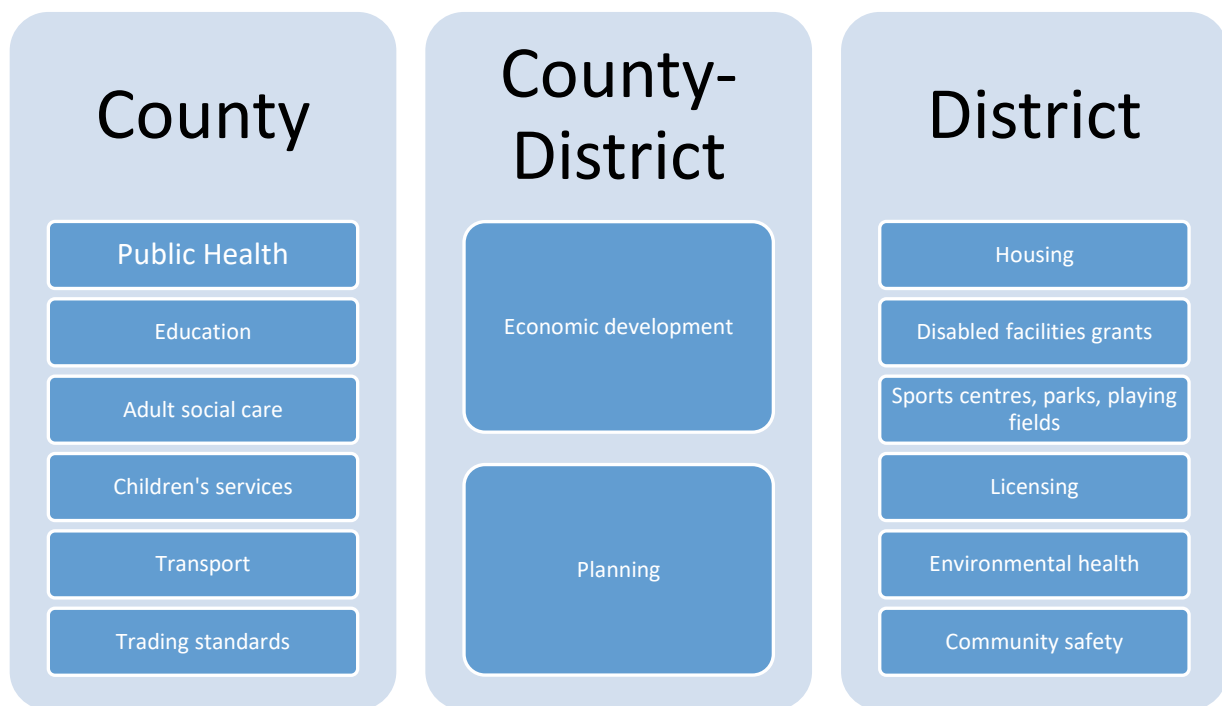On average, counties commissioned 33,429 NHS health checks...

....compared to a national average of 12, 231

63% more

A FAIRER FUTURE FOR COUNTIES
COUNTY COUNCILS NETWORK

3.30   Our analysis of the interviews suggest that there are two important dimensions to the question of scale. First, capacity which is seen by many interviewees as being a key factor in the quality of the new relationship between public health and the health service. One interviewee from the NHS contrasted his experience of working with a large county unitary and a smaller unitary and said that relations were far stronger with the former. Second, the fact that county geographies are closer to health geographies, particularly in the context of sustainability and transformation partnerships and integrated care systems.

3.31   Secondly, interviewees also pointed to the relevance for public health of the relationship between county and district councils in two tier areas. As outlined in the diagram below, the split of responsibilities between county and district authorities include a number of services that directly influence the wider determinants of health and wellbeing, e.g. housing, planning, environmental health, recreation and leisure.

County	County-District	District
Public Health	Economic development	Housing
Education		Disabled facilities grants
Adult social care		Sports centres, parks, playing fields
Children's services	Planning	Licensing
Transport		Environmental health
Trading standards		Community safety

3.32   We explore this factor in more detail in the next section, but at this stage it is important to make two points:

- Despite the challenges and tensions of two tier working we were pointed to several examples of effective joint working on topics such as housing, planning, fuel poverty, leisure and physical activity;

- A number of DsPH made the point that they have found it easier to engage with districts from within local government than they did from within the NHS.

Health partners

3.33   In painting a picture of the impact of the transfer it is important to acknowledge that the widely positive view within local government is not matched within the health service where most of the

people we interviewed were at best sceptical about the impact of the transfer and in some cases consider that it was a mistake. The views of the people in the health service who we spoke to in county areas are shared by the national stakeholders we interviewed.

> ### "The transfer was a mistake, a bit of a disaster."
>
> CCG accountable officer

> ### "Public health has become remote, not in touch with the reality of primary care."
>
> CCG accountable officer

3.34   We have identified five aspects to the concerns within the health service.

3.35   First, there are concerns that responsibility for commissioning key services has become fragmented with detrimental consequences for the individuals and groups concerned. Examples quoted include smoking cessation, sexual health, breast feeding and drugs and alcohol services.

> ### "There is a degree of disjointed responsibility"
>
> Director of public health

3.36   Second, health providers in particular say that they are having to deal with the consequences of reduced resources for public health as a result of government reductions to ring-fenced grant funding. As noted earlier, however, most of the people we talked to did not think that the public health budget would have escaped from similar levels of cuts had it remained in the NHS.

3.37   Third, people in the NHS are sceptical about the extent to which action on the wider determinants of health is happening and whether it is having any tangible impact on health outcomes.

3.38   Fourth, some interviewees were concerned that public health in local government did not have the capacity or status and profile to take the action that is needed.
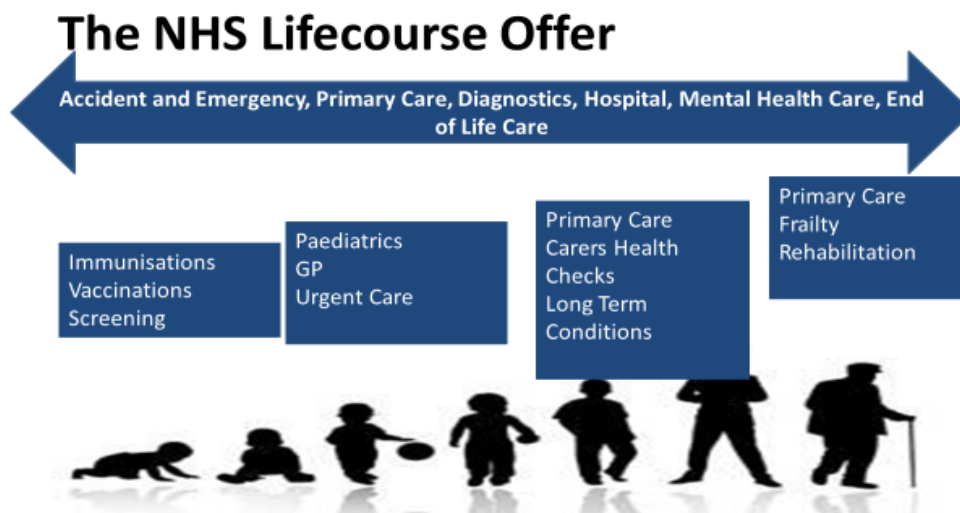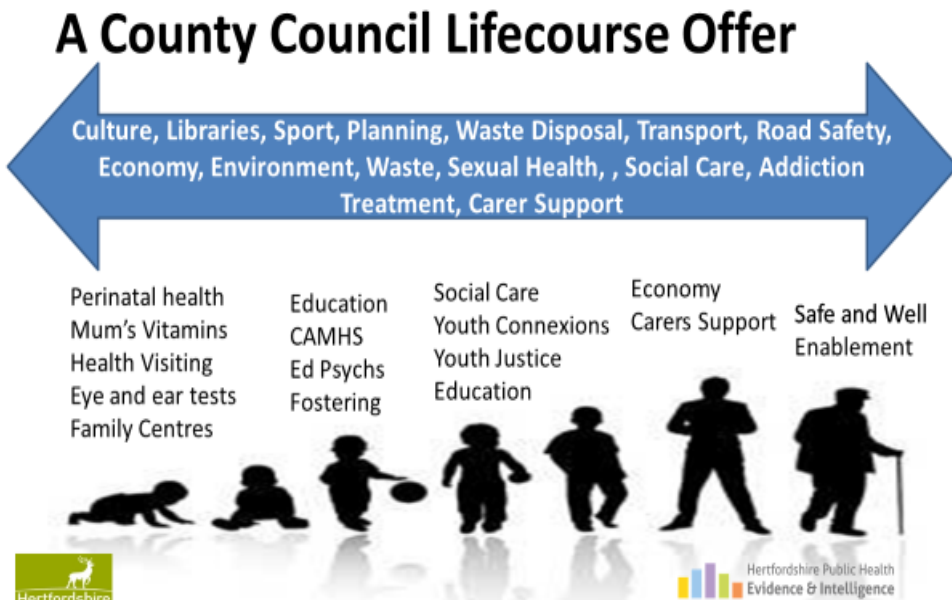
3.39   Finally, people in the health service are concerned that public health has become distant from them and that as a result the NHS often lacks a coherent public health and population health voice. The tables below[17] set out what could form the basis of an understanding of the distinctive roles of the health service and local government across the life course.

3.40   It is clear from our interviewees that councils, DsPH and their teams put significant effort into their relationship with the health service. It is also stressed that there had been serious concerns about the status of public health when it was part of the NHS and that its budget was vulnerable to be "raided" in that setting.

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[17] Presented by Jim McManus, Director of Public Health, Hertfordshire at the 2018 CCN Conference

"We have good relations with the NHS. The traction of public health within the NHS may not be as strong as it was, but the move away from a medically-driven model of public health was an important move."

Local authority chief executive

A County Council Lifecourse Offer

Culture, Libraries, Sport, Planning, Waste Disposal, Transport, Road Safety, Economy, Environment, Waste, Sexual Health, , Social Care, Addiction Treatment, Carer Support

Perinatal health
Mum's Vitamins
Health Visiting
Eye and ear tests
Family Centres

Education
CAMHS
Ed Psychs
Fostering

Social Care
Youth Connexions
Youth Justice
Education

Economy
Carers Support

Safe and Well
Enablement

Hertfordshire

Hertfordshire Public Health
Evidence & Intelligence

The NHS Lifecourse Offer

Accident and Emergency, Primary Care, Diagnostics, Hospital, Mental Health Care, End of Life Care

Immunisations
Vaccinations
Screening

Paediatrics
GP
Urgent Care

Primary Care
Carers Health
Checks
Long Term
Conditions

Primary Care
Frailty
Rehabilitation

3.41 Many interviewees within local government, however, accept that there is a danger that the links between health commissioners and providers and public health in local government are not as close as they should be. There is also a view that this is not just a consequence of the mechanics of the transfer, but also reflects deeper-seated tensions between a clinically-focussed approach to public health and a more place-based one.

3.42 Our literature review reinforced the need to pay attention to the relationship between public health and the NHS. Fragmentation of responsibility between local government and the NHS has been identified in earlier research as an issue which can lead to delays in commissioning and tensions between organisations. The LGA's report also warns that one consequence of successfully integrating public health with other council functions could be that public health loses a distinct identity. It adds: "it is important that local government continues to be able to draw on public health techniques and expertise."

> "People in the NHS don't think about public health automatically. The link back into the health service is not as strong as it should be. The CCG has lost sight of it."

> Director of public health

3.43 These concerns are reflected in the NHS Long Term Plan which states that as many preventative health services commissioned by public health teams "are closely linked to NHS care, and in many cases provided by NHS trusts, the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors and school nurses, and what best future commissioning arrangements might therefore be.

3.44 Responding to the plan the chief executive of Public Health England said that it would lead to a joint review between local government and the NHS to achieve better joined up working on public health[18]. This research has also identified the need for a reboot of the relationship between public health in local government and the health service and our conclusions should help to inform this review. This is an issue we explore further in the next section.

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[18] Local Government Chronicle 9 January 2019

4   The drivers and barriers to effectiveness

4.1   Drawing on the findings of our interviews we have concluded that there are four areas which are key to the effectiveness of public health in local government. They are:

- The position of public health within the council;

- In two tier areas, the nature of the relationship with district councils;

- The nature of the relationship with CCGs and health providers;

- Geography.

The following sections explore each of these areas in turn. This section concludes by exploring the role of health and wellbeing boards in this context.

Position within the council

4.2   The DoH's 2012 advice note was quite clear that, in order to deliver the government's vision for the role of the DPH, "we would expect there to be direct accountability between the director of public health and the local authority chief executive (or other head of paid service).

4.3   When the transfer took place the status and position of the DPH was a contentious and contested issue. Should they report to the chief executive? Should they be on the corporate management team? Did they have a similar status to other "statutory" officers.

4.4   Our research suggests that the position of public health in the council is important. Drawing on our interviews it is possible to paint two broad pictures of the position of public health in county councils.

> ## "The public health function must be able to influence all parts of the council."
>
> Local authority chief executive

4.5   In one picture the public health function sits at the corporate core of the council. The task of marshalling action on the wider determinants of health is centre stage, while not neglecting mandatory and commissioned services. In this picture the DPH either reports to the chief executive or has regular meetings with her or him. This is an aspirational, place-focussed function.

> ## "My chief executive sees the benefits of public health underpinning everything the council does."
>
> Director of public health reporting to the chief executive

4.6   In the other picture public health is seen as a people service, sitting alongside adult and children's services. The main focus of activity is often on commissioned services with less progress being made on the wider determinants. In this picture the DPH reports to the director of people or director of adult social services. This is a setting in which financial pressures tend to be centre stage.

"The complexity of the work is not yet fully understood…we are still influencing from the side."

Director of public health in a people directorate

4.7   A desk-based analysis of the reporting lines of DsPH in county councils suggests that just under half (44 per cent) report directly to the chief executive and just over half report to an executive director. The reality can be more complex than this. Some DsPH have taken on more senior, wider roles. Others report to directors of place rather than people. And it is important to acknowledge that influence is not necessarily determined by status or position within an organisation, and the interests, capabilities and attitude of the DPH and her or his senior colleagues are also significant factors.

4.8   Two other pieces of qualitative evidence are important.

4.9   First, those DsPH who either report to the chief executive or have regular meetings with her or him speak positively about the progress they are making in influencing the wider determinants. Those who report to a DASS or Director of People are less positive and talk more about challenges than successes.

"Public health is seen about meeting obligations rather than adding value."

Director of public health in a people directorate

4.10   Second, two of the chief executives we interviewed had strong views on this topic. One was clear in 2013 that the public health function should not be located alongside adult social care. "That would have hampered its ability to influence the rest of the council. I enjoy having the DPH at the management team table. He thinks differently." One of the first steps the second chief executive took when he was appointed to a county role was to reorganise so that the DPH reported directly to him. "That was important because the DPH needs an ability to influence corporately and have easy access to me."

4.11   The attitude of health partners is also relevant to this question. The health stakeholders we interviewed nationally and locally saw the status of many DsPH as confirmatory evidence of what they perceive as a diminution of the role of public health following the transfer. This factor was also mentioned by the two chief executives referred to above both of whom were keen to ensure that their DPH had the clout and status to punch their weight in the NHS world – a world in which status is seen to matter more than in local government.

4.12   As one of the chief executives said: "The public health team fought hard when it was in a clinical setting, it now has a stronger voice in local government. It is part of the job of the chief executive to create the conditions in which that voice can be heard." He added: "Health and wellbeing must be a priority for a chief executive. This means that a chief executive who doesn't have a direct link with the DPH is missing a trick."

The relationship with districts

4.13   One of the distinctive features of the transfer of public health in many county areas is that responsibility for the wider determinants of health is split between the county and district and

borough councils. In particular, district councils are responsible for housing, recreation and leisure, environmental health and planning. In these areas county councils, in addition to their public health responsibilities, are responsible for transport, rights of way, trading standards and education all of which impact upon the wider determinants. [19] This clearly raises challenges that do not exist in unitary councils, but as some interviewees commented, it is naive to assume that collaboration between functions in a large unitary is always easy.

4.14   Several of the DsPH we interviewed identified relationships in two tier areas as a significant challenge and an obstacle to marshalling action on the wider determinants. This was particularly the case in places where county-district relations are particularly difficult and contested. Interviewees also highlighted the challenge of establishing a consistent approach across a two-tier county.

> "We are working with our districts on planning, social value, health in all our policies. This wasn't on the agenda when public health was in the NHS, but it is now and I like the way it is being taken forward."

> Director of public health

4.15   There are, however, examples of effective collaboration between counties and districts on public health issues. Where it works two organisations collaborating on a topic can deliver added value, and in some places collaboration on public health initiatives has acted as a trailblazer for wider joint working. Some interviewees perceived public health as a driver of collaboration between the different councils in a county. One county has recently commissioned health and wellbeing hubs with the districts and is in the process of agreeing health and wellbeing deals with them. The hubs provide advice and support on steps people can take to improve their health and wellbeing. Another county is pursuing county-district collaboration on a range of topics including fuel poverty and physical activity.

The relationship with health

4.16   As we noted in the previous section there is widespread scepticism about the impact of the transfer in the NHS. In some cases this scepticism is reinforced by perceptions of the status of the public heath function and director within the council. In a comment which resonates with the views of two council chief executives, one health service interviewee said that the fact the DPH did not report direct to the chief executive meant that the function was not seen as being important.

> "Gaining more traction with the NHS is absolutely key. If we don't get this right we'll have a narrow version of public health focussing on place without any traction in the wider health system."

> National stakeholder

4.17   There are a number of issues relating to the link between public health in local government and the NHS which DsPH and their NHS colleagues agree require attention including:

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[19] https://www.lgiu.org.uk/local-government-facts-and-figures/

- The gulf which many people perceive is emerging between the two;

- The risk of fragmentation in relation to the commissioning of some services.

4.18   It is clear from our interviews that local government's approach to commissioning and procurement provides the basis for a new relationship between public health teams and NHS provider trusts which some interviewees in the NHS welcome.

4.19   Our DPH interviewees have highlighted the steps that many of them are taking to maintain and develop effective relationships with their NHS colleagues and organisations. These include:

- Personal efforts by the DPH to retain personal links, serve on CCG accountable bodies and participate and in some cases lead STP and Integrated care systems discussions;

- A variety of staff arrangements including basing public health staff in NHS organisations for various periods time; jointly funding posts and co-locating staff.

4.20   We are aware of one NHS trust which has employed a public health consultant. This has been variously described as a symptom of a problem and a good example of collaboration.

Geography

4.21   One barrier to effective working with the health service is geography and, in particular a lack of coterminosity between organisations and planning areas.

4.22   In considering this point in the context of the transfer of public health to counties, the scale of partnership arrangements and complexity of local health economies are vast, with over 60 acute trusts and approximately 80 CCGs operating in county localities.[20] Additional complexity has been overlaid in county through the geographies of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS).

4.23   Many public health teams in other areas have the challenge of dealing with more than one CCG, often "shared" with another council. This has significant implications for the resource and capacity required to develop a coherent public health contribution to health commissioning and provision.

Health and Wellbeing Boards

4.24   Many of our interviewees identified health and wellbeing boards as an important feature of the new public health landscape, particularly in terms of mobilising action on the wider determinants of health.

4.25   For Health and Wellbeing Boards in two-tier areas there has been much debate about the best way in which to engage a broader range of health partners and those that directly influence the wider determinants. District councils, for instance, are not statutory members of HWB boards.

4.26   Many HWBs have taken the decision to include non-statutory members, for example additional elected members, representatives of district and borough councils, the police, healthcare providers,

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[20] https://www.countycouncilsnetwork.org.uk/download/1012/

the voluntary sector and other organisations.[21] Some counties have responded to this challenge by establishing sub-county level partnerships to feed into county-wide arrangements.

4.27   In our analysis of the interviews, however, the boards have not featured as a key driver of or barrier to the impact of the transfer in a particular area; and despite the key role of health commissioners (and in some cases providers) on them, they do not seem to have helped bridge the emerging gap between the health service and the local government public health system.

4.28   What is striking, however, are the common themes between this research and some of the findings of research we carried out for the LGA on the effectiveness of health and wellbeing boards. In our most recent report[22] we identified five factors which have a significant influence on the effectiveness or not of a HWB. They are:

- A focus on place, as the most effective HWBs act as anchors of place;

- Committed leadership. Exerting influence across the council, place and health and care system;

- Collaborative plumbing, to underpin the leadership of place and influence the STP;

- A geography that works, or the capacity to make the geography work;

- a DPH that gets it, and who can support place-based leadership.

4.29   Our analysis, as previously shown, suggest that a DPH who gets it is most likely to report direct to the chief executive.

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[21] https://www.research.manchester.ac.uk/portal/files/54552121/FULL_TEXT.PDF
[22] The Power of Place: HWBs in 2017 (April 2017)

5 Conclusions and recommendations

5.1 The NHS Long Term Plan was published between the completion of the research for this report and its publication. It commits the NHS to acting to complement the role of individuals, communities, businesses and government in shaping the health of the nation. As noted above it has also initiated a review to secure better joint working between the NHS and local government on public health.

5.2 This research shows that councils in county areas are mobilising the wider determinants of health to deliver the preventative approach that underpins the long term plan. It has also identified a number of areas in which action is required in order to build on the achievements to date.

5.3 The local government stakeholders we interviewed in 14 county areas are positive about the impact of the transfer of public health to local government. They all quote examples of public health teams working across the full range of council functions to improve health and wellbeing, ranging from an integrated approach to services for children to action on air quality and active transport. They report that councillors are acting as powerful advocates for public health and that local authority commissioning and procurement expertise is benefitting commissioned services. This supports the conclusions of earlier research on the impact of the transfer.

5.4 Some DsPHs are more confident about their effectiveness in working with council colleagues to mobilise the wider determinants of health. These tend to be DsPH who report directly to their chief executive and who see their role very much in place terms.

5.5 Those councils which have the capacity to devote to building and maintaining links with health providers and commissioners point to constructive relationships with the health service. But all of our interviews point to a gap developing between the NHS and health in local government. Interviewees in the health service attribute this to factors such as fragmentation and reductions in resources, but it also reflects the need for a new understanding of the role of public health in the context of health and care integration and the importance of prevention.

5.6 Other factors that are influencing the impact of the transfer in county areas are the nature of county-district relations and the complexity of local organisational geography.

5.7 The core conclusion of this research is that government was right to be ambitious about the potential of local government to take the lead in improving health locally, working closely with local partners and exploiting the full breadth of its remit. DsPH and their colleagues are most confident about achieving that ambition where public health has an overtly place-based focus. Significantly that is also true of health and wellbeing boards.

5.8 If the government's objectives for health and care integration and prevention are to be achieved it is essential it builds on the wider place-based role of county councils and their district partners, not simply their role as social services authorities and commissioners of public health and care services. This will require a new relationship between health and local government including the role of public health.

5.9   It is clear from this research that there is significant scope for learning between councils in order to secure greater benefits from the transfer and ensure that the factors identified above act as drivers of an effective function. We recommend that CCN should facilitate learning and sharing between its members on the following topics:

- Mobilising the full range of local government services to improve health and wellbeing and support a preventative approach;

- Good practice on commissioning, procurement and innovative approaches to service delivery;

- The most appropriate organisational settings for an effective public health function;

- The role of public health in contributing to and benefitting from county-district relations;

- Building effective links with CCGs and health providers.

SHARED INTELLIGENCE