ADCS/ADASS joint submission to the Health Select Committee Public Health Inquiry

1. Introduction

1.1 ADCS and ADASS members are jointly responsible through the activities of their departments for the wellbeing, protection and care of their local communities and for the promotion of their wellbeing and protection through the use of direct services and the co-ordination of, and liaison with the NHS and other statutory agencies, voluntary agencies, and private companies.

1.2 ADCS and ADASS members have leadership responsibilities in local authorities to promote community engagement, local access to services and to drive partnership working to deliver better outcomes for local populations, based on a full understanding of local need. They participate in the planning, delivery and commissioning of the full range of council services and influence the direction of planning through formal and informal partnership arrangements with a range of partners which include the NHS and allied health professionals. We have particularly strong experience in working in partnership to design and deliver effective early intervention and prevention programmes.

1.3 We welcome the Select Committee's inquiry and the opportunity it presents to further scrutinise public health proposals. We believe that Government has set a broadly positive direction for public health. However, notwithstanding the current 'pause' in the passage of the Health and Social Care Bill, we are concerned that our ability to understand fully the proposed public health landscape is limited by the passages of both the Health and Social Care Bill and Localism Bill concurrently with consultations on the Public Health White Paper, and by the lack of detail on funding and accountability arrangements in the new proposals.

1.4 Local authorities remain committed to working with our partners to absorb, navigate and develop the new arrangements to the benefit of our local communities. We believe that local authorities are in a good position to provide a degree of stability in a time of turbulence resulting from the pace of change and immaturity of the emerging structures. We are keen that local authorities are able to share their expertise in managing transition with the new structures. There are over 130 shadow Health and Wellbeing Boards in operation, developing early local approaches to ensuring focus and accountability on improved outcomes, including addressing health inequalities, in the proposed system. Our evidence is based on these experiences and our experience working collaboratively in recent years.

2. Summary

- Local authorities have significant experience working collaboratively with a range of partners to plan and deliver public health initiatives to improve the lives of local people. We welcome government's intention to return to local authorities a leading role in improving, promoting and protecting the health of their communities.

- We are concerned by a lack of clarity on responsibility, accountability and scrutiny in proposed new elements of the public health system.
- We recognise the important role of GPs in the design and delivery of local public health services but public health and wellbeing provision cannot be solely rooted in a medical model. A wide range of partners must be involved from design, through delivery and to review.
- Schools make a crucial contribution to achieving improved public health outcomes, but we are concerned that limited reference to this in the proposals alongside both increased autonomy of schools and a requirement only to 'have regard to' public health priorities may risk the contribution they make in future.
- We welcome the move of directors of public health to local authorities and we note a range of approaches emerging to the integration of this role into local authorities. We would welcome further discussion to determine an approach that ensures a coherent system, service continuity and transparency whilst allowing for necessary local flexibility.
- Health and Wellbeing Boards should be given statutory powers both to sign-off local commissioning plans from all partners and to hold these commissioners to account against their plans. The status of Joint Strategic Needs Assessments (JSNAs) should be strengthened with clear duties on commissioners to take account of Health and Wellbeing strategies in their commissioning plans.
- We are concerned that the prioritisation of the needs of vulnerable children, young people and adults, who are at risk of being out of the reach of public health initiatives, has yet to be embedded in the new arrangements. Reflection of their stories in the JSNA alongside sufficient representation of the needs of these groups on planning and commissioning bodies is crucial.
- A match between the level of ambition of reform of the system and resources available must be made.
- The health premium appears to incentivise short-term approaches and, to successfully contribute to addressing health inequalities should be restructured to incentivise long-term solutions, and be weighted towards areas facing high levels of deprivation.

3. Public health architecture and the role of the local authority

3.1 We welcome Government's intention set out in *Healthy Lives, Health People* to return to local authorities a leading role in improving, promoting and protecting the health of their communities.

3.2 The proposed structures outlined in the White Paper appear to build on established and successful collaborative working and integrated approaches between the NHS, local authorities and a number of other partners in recent years. We welcome the extension of collaborative arrangements intended to create services that collectively address the health and wellbeing needs of local people and populations.

3.3 We remain concerned that the White Paper and the Health and Social Care Bill provide little detail on the structure intended to deliver these reforms, or the extent to which local areas will be able to determine and build their own structures reflective of their own individual needs. The Consultation on Funding and Commissioning Routes for Public Health begins to set out the different responsibilities of the various organisations in the proposed new public health system, the intended relationship between Public Health England, the NHS Commissioning Boards, Monitor, HealthWatch, the Health and Wellbeing Boards and, ultimately, GP Consortia, remains unclear.

3.4 We are also concerned that the proposed governance structure remains ambiguous, with a confusing mixture of national and local direction. Proposals offer no clear detail on lines of accountability and scrutiny in the system.

3.5 We accept the crucial role GPs play in the design and delivery of local public health services, but we firmly believe that health and wellbeing cannot be solely rooted in a medical model. Public health must involve a wide range of partners from design through to delivery and review. We note that proposals for GP Consortia do not place any limitations on the formation of Consortia in terms of geography. Although we recognise the advantages of GP Consortia forming in such a way that reflects best the local communities which they serve, we are concerned that the potential lack of alignment between different structures and layers within the new local public health system may present significant challenges to integrated approaches.

3.6 We are also concerned about the limited reference to the critical role of schools in the public health agenda, particularly in the health promotion and early intervention initiatives that are undertaken within school settings, such as healthy eating, exercise and efforts to reduce teenage pregnancies and improve the sexual health of young people. We are concerned that the important role of schools in delivering local public health agendas may be further diluted by the requirement on academies and free schools only to 'have regard to' public health priorities, potentially limiting local capacity to develop cohesive and strategic local public health agendas.

4. Directors of Public Health

4.1 The role of the Director of Public Health (DPH) in each local authority will be key to supporting individual GPs and GP Consortia to address their public health responsibilities. We welcome the movement of the DPH to local authorities. We believe this reinforces a broader approach to health and wellbeing both within wider local authority activities, such as housing, transport and planning, as well as in the core business of addressing health inequalities. We believe DPHs will provide a critical role in straddling and brokering the professional relationships between health (GP Consortia, NHS) and local authorities to draw out the full advantages that each stakeholder can bring to improving health outcomes and tackling health inequalities.

4.2 We have already noticed a range of approaches emerging to the assimilation of DPHs into local authority structures. Some DPHs report directly to local authority chief executives and others to the director of adult services/ community services. Similarly, there is divergence on the definition of the role of DPHs, with some defined as clinical specialists and others as knowledge leaders. We also note confusion on the accountability and division of responsibility for this role between Public Health England and local authorities. Given the critical role of DPHs in the new system, we would welcome further discussion to determine an approach which ensures a coherent system, service continuity, and transparency for this role whilst allowing for flexibility to respond to local contexts.

4.3 ADCS and ADASS agree that voluntary registration for Directors of Public Health is insufficient. We believe that there should either be compulsory registration or none at all.

5. Planning and commissioning

5.1 We believe the proposed Health and Wellbeing Boards will be critical to the dynamics of local commissioning and we have strongly urged that the Boards are

given statutory powers to both sign-off local commissioning plans from all partners and to hold these commissioners from across GP Consortia, Public Health England, the NHS and local authorities to account against their commissioning plans. To complement the enhanced role of the Health and Wellbeing Boards, we also urge that the status of the Health and Wellbeing Strategies and the Joint Strategic Needs Assessments (JSNA) be strengthened, with clear duties on commissioners to take account of Health and Wellbeing Strategies within their commissioning plans.

5.2 We remain concerned that, at times, the needs and stories of children and young people and marginalised adults, such as adults with learning disabilities can be lost in the accumulation of information and evidence as part of the JSNA. We strongly suggest that in any efforts to build a local evidence base through the JSNA, and in the efforts of Public Health England to build a national evidence base, full attention is given to the lives and needs of children and young people and marginalised adults in order to ensure both general needs and the specific needs and wishes of the most vulnerable in our local communities are met.

5.3 We are particularly concerned that there appears to be potentially inadequate representation of the needs of children and young people in the planning and commissioning arrangements in the proposed system. ADCS remains concerned that there is only one 'Children Services' representative on the Health and Wellbeing Boards (Director of Children Services). We would expect that in any new arrangements, all partners are cognisant of their wider roles to improve the outcomes for children and young people and see this as part of their core responsibilities; this is particularly pertinent for the shared responsibility to safeguarding arrangements. While accepting that there are proposals to transfer safeguarding responsibilities currently held by PCTs and SHAs to the new health infrastructure, we are concerned that these responsibilities may become diluted and/or fragmented across the range of new structures and systems delivering health care.

5.4 ADCS is concerned that the lack of children's services representation at planning and commissioning stages in conjunction with lack of clarity over relationships between components of the new system may lead to further fragmentation across an increasingly divergent set of arrangements, for example responsibility for health care of pregnant women or the exact accountability and reporting arrangements for directors of public health. We are concerned about the lack of clarity over positioning of child and family poverty strategy in the new system. We believe this will be compounded by a fragmented approach in national policy, particularly between government departments towards responsibility for children and family services and resulting differences in approach, for example "individualism" in the Department of Health and "families" in the Department for Education.

5.5 We are particularly concerned that the detail on how the specific needs of looked after children and vulnerable children and adults will be prioritised in revised arrangements is yet to be developed. It is these groups of children, young people and adults who need support and care the most and who often suffer from a lack of public health initiatives. It is vital that these particular groups are considered within the roles and responsibilities between Public Health England, GP Consortia, and the NHS Commissioning Board. We particularly note the lack of a joined up approach to the planning, development and delivery of services for children and adults with mental health needs. We have urged Government to provide further detail on its expectations in this regard and suggest consideration

of work by the Joint Commissioning Panel for Mental Health (JCP-MH), a collaborative approach by 13 organisations, including ADASS, to develop practical guidance for commissioners of mental health and wellbeing services.

6. Arrangements for the funding of public health

6.1 Clearly, the allocation of sufficient resources is crucial to effective implementation of the measures set out in the White Paper. Although we acknowledge the limitations of the current economic climate, there must be a match between the level of ambition and the resources made available to meet that ambition. We have sought urgent clarification on the level of allocation provided to local authorities to:

- meet the expectations detailed in the White Paper;
- match the level of deprivation (aligned to evidence detailed in the JSNAs), with clear reference to accommodating the compounded impacts of high density deprivation and health inequalities in particular areas, reducing their ability to qualify for the health premium – these areas must be supported rather than penalised;
- make adequate provision for a minimum floor to ensure smaller councils are not disproportionately disadvantaged.

6.2 We note confusion regarding the status of the ring-fence proposed for the public health budget and are concerned that this may create tensions between localism and national direction. We would welcome further debate on how to balance local and national tensions based on greater clarity on the structure of the new arrangements, including the relationship between different government departments and their demands on the public health ring-fence. We are keen to explore further how community budgets can fit within the proposed reforms, with a emphasis on closer integration, shared priorities and a consistent and coherent governance framework operated at the local level through the Health and Wellbeing Boards.

6.3 We know that the causes of health inequalities are complex, deeply rooted and are often compounded in areas experiencing both high levels of multiple deprivation alongside very transient populations. It is these areas which particularly require long-term sustained solutions. We are concerned that proposals for a health premium as set out in the White Paper appear to incentivise a more short-term approach and that the extent of local discretion afforded to commissioners is very likely to exacerbate this tension. To mitigate this, we have urged Government to consider:

- restructuring the health premium to incentivise long-term solutions to health inequalities, weighted towards areas facing high levels of deprivation;
- strengthening the role of Health and Wellbeing Boards to hold all partners with commissioning responsibilities to account against the local Health and Wellbeing Strategies focussed on addressing long term health inequalities; and
- weighting the funding allocation towards areas with high levels of deprivation, multiple deprivations and/or high health and wellbeing needs.

6.4 We also suggest that the Health and Wellbeing Strategies be consistently aligned to the six health inequalities priorities identified in the Marmot Review. This will provide cohesion and focus, as well as a more long-term and sustainable approach to reducing health inequalities. We appreciate the need to accommodate local accountability to meet specific needs of local communities alongside broader strategic objectives.

6.5 It is widely acknowledged that there is a strong correlation between prevention and early intervention and up-stream benefits (improved outcomes and reduced costs). The White Paper clearly aligns to this philosophy but there is limited evidence as to how this can be taken forward in a consistent, cohesive and strategic way. We are concerned that the extent of local discretion, limitations on commissioning accountability and oversight, and the construct of the health premiums do not encourage a more structured approach. There are continued risks that more long-term and seemingly more intractable health inequalities are avoided for more short term "easy wins". This will significantly disadvantage those areas with the greatest level of health inequality.

6.6 We are keen to address the relationship between prevention and early intervention with partners and we welcome further discussion regarding how best to address this inter-dependency. We strongly believe that the solutions are held locally but that to realize mutual benefit, the whole approach must be localised with appropriate and equitable funding allocations. We are concerned that important local public health opportunities may be missed as Government continues to encourage local authorities to allocate resources from depleted early intervention and prevention funds in the now amalgamated Early Intervention Grant to specific ministerial priorities, reducing scope for local decision making to meet the needs of local populations.

6.7 We believe a key issue remains the challenges of information sharing. Information sharing protocols are developed but these remain unwieldy. Any efforts in easing these barriers to sharing information while maintaining the confidentiality of the person would be of huge benefit.

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