

ADCS/ADASS joint response to public health white paper consultation:

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, voluntary agencies, private companies and other statutory organisations.

ADCS and ADASS members have leadership responsibilities in local authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. 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.

Introduction

We welcome Government's intentions as set out in *Healthy Lives, Healthy People* to return to local authorities a leading role in improving, promoting and protecting the health of their communities. We are encouraged by the aspects of the White Paper which implement the principle of localism and acknowledge the range of council activity that has a direct positive influence on addressing local health inequalities.

We believe that the White Paper sets a positive direction for public health. However, we are concerned that our ability to understand fully the proposed landscape set out by Government 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.

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 needs to be a match between the level of ambition and the resources made available to meet that ambition. We seek 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 of deprivation and health inequalities in particular areas, reducing their ability to achieve 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.

We have further concerns regarding the structure of the new system and potential dilution of priority given to services to vulnerable children, families and adults. We raise these concerns in our answers to the questions posed in the consultation below.

a. Role of GPs and GP practices in public health: *Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?*

Although we accept the crucial role GPs play in the design and delivery of local public health services, 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. Our response to this question below reflects this approach.

Local authorities remain committed to working with GPs, and other partners, as we have endeavoured to do for many years, as we absorb these new arrangements. Our views are based on our experiences working collaboratively in recent years and the following comments, we believe, will support us in taking this work forward.

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. However, we are 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.

Although 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, we are not clear of the intended relationship between Public Health England, the NHS Commissioning Boards, Monitor, HealthWatch, the Health and Wellbeing Boards and, ultimately, GP Consortia.

We note that proposals set out in the White Paper 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. We seek urgent clarification from government on how different elements of the proposed system will relate to and work with each other.

We are also concerned that the proposed governance structure is too ambiguous, with a confusing mixture of national and local direction and offers no clear proposals on lines of accountability and scrutiny in the system. We believe the proposed Health and Wellbeing Boards will be critical to the dynamics of local commissioning and we strongly urge 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.

Until further detail is known about the intended structure and funding arrangements, to support activities at the various levels, it is difficult to comment on the success with which those activities will be delivered. We urge Government to consider maximising the resources available at the local level in order to ensure the greatest impact on health outcomes for the local population and to avoid using resources currently within PCTs for Public Health to support national or sub-national structures.

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. For example, ADCS takes the view 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. We seek reassurance that this will not be the case.

We seek acknowledgment from Government that looked after children and vulnerable children will not be forgotten about in any revised arrangements. It is this group of children and young people who need support and care the most and who often suffer from a lack of public health initiatives. It is therefore vital that these particular groups of children 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 urge 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.

Local authorities will support where possible in sharing our experiences and knowledge as to how best to make sure the needs of these groups of children and young people and marginalised adults are not overlooked when rolling out national public health services. However, ADCS is particularly 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 of Education. Similarly, 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.

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.

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 with Government to agree an approach which ensures a coherent system, service continuity, and transparency for this role whilst allowing for flexibility to respond to local contexts.

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 is further diluted by the development of academies and free schools who must only have regard to public health priorities, potentially limiting local capacity to develop cohesive and strategic local public health agendas.

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, particularly GP Consortia. We also note that transition of this type and scale will have complex human resources components to it and we would support the early identification of a HR Strategy specifically for those staff involved to be developed in conjunction with councils.

b. Public health evidence: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

The current range of partners focussed on building research and evidence bases, including C4EO, RIP, RIPfA and SCIE, have been invaluable in supporting local areas to develop informed and evidence driven strategies and plans to improve outcomes for our local communities.

Improving the availability, accessibility and utility of public health information will be reliant on the successful development of the Joint Strategic Needs Assessment

(JSNA), and mechanisms to feed information from them into a national database to avoid both duplication of effort and evidence.

Local authorities are developing their own systems to provide up-to-date information that can be uploaded regularly and generates a picture of the current health and wellbeing of their local communities as a means of supporting activity and the development of plans and strategies to continue health improvement going forward. Any system developed nationally must also be easily accessible to these local systems as a means of enabling and promoting the sharing of information.

Working in close partnership with the Health Observatories, local authorities are skilled and experienced in the application of JSNAs and as such are able to offer further support to commissioners in understanding local needs. We recognise JSNAs can be improved and we support the development of more accessible and localised profiles that provide commissioners with powerful evidence-based intelligence, particularly to ensure small cohorts of need are not overlooked.

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. We urge Government to approach the sector to support the development of these aspects of information and evidence gathering to ensure children and young people and marginalised adults are not overlooked.

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 exasperate this tension. To mitigate this, we urge 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.

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.

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 with 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.

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.

We believe a key issue remains the challenges of information sharing. A significant hurdle in the development of local services has been the barriers, perceived or otherwise of sharing information across organisations and professions. 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.

c. Public health evidence: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

As already noted the use of a locally developed JSNA will be key. What we are worried about however is that the range of responsibilities allocated to PHE do have the potential to create confusion and delays in making sure families receive the care they need. This is primarily because of the dispersal of responsibilities to a further organisation that is too far removed to the experiences on the ground. If the functions of public health are to be the responsibilities of LAs we would want to see these responsibilities handed over fully rather than piecemeal.

Experience of working with large local and regional arrangements show how short, medium and long term planning and delivery of care and support services can be made unnecessarily difficult because of the fragmentation of responsibilities and the challenges of bringing the pieces of the jigsaw back together through the use of pooled budgets and local agreements. This creates an unnecessary layer of bureaucracy and use of funds to police and monitor as opposed to undertaking the tasks which will make a difference.

We firmly believe that the transfer of public health responsibilities into the LA will provide significant opportunities to address the gaps and concerns we have for our local communities. Through our recent experiences and increased knowledge and evidence base we do firmly agree that this is the ideal arrangement. We also know however through extensive experience of the challenges of working with centralisation of activity can bring in our local efforts in meeting the needs of our local communities. We would therefore like to offer our help in developing further the

remit and range of responsibilities of the new arrangements as a way of sharing our own experiences as a means of making sure these arrangements enable and promote the work necessary to continue making a difference to our local communities.

d. Public health evidence: *What can wider partners nationally and locally contribute to improving the use of evidence in public health?*

The impact such organisations as C4EO, RIP, RIPfA and SCIE have had on local areas thinking more purposefully about use of evidence and research in local areas has been significant. There is always scope for improvement and the sector will be more than willing to share these experiences to support the development of PHE.

e. Regulation of public health professionals: *We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?*

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.

This consultation response was prepared on behalf of the ADCS/ADASS Joint Committee, Sandie Keene (Director of Adult Social Services at Leeds), Glyn Jones (Director of Adult Social Care and Health at Bracknell Forest) and Richard Jones (President of ADASS).

Any further enquiries about the content of this response can be directed to Jonathan Gardam (ADASS) at jonathan.gardam@adass.org.uk and Zoe Williams (ADCS) at zoe.williams@adcs.org.uk