RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

The views of public health teams working in local authorities Year 1

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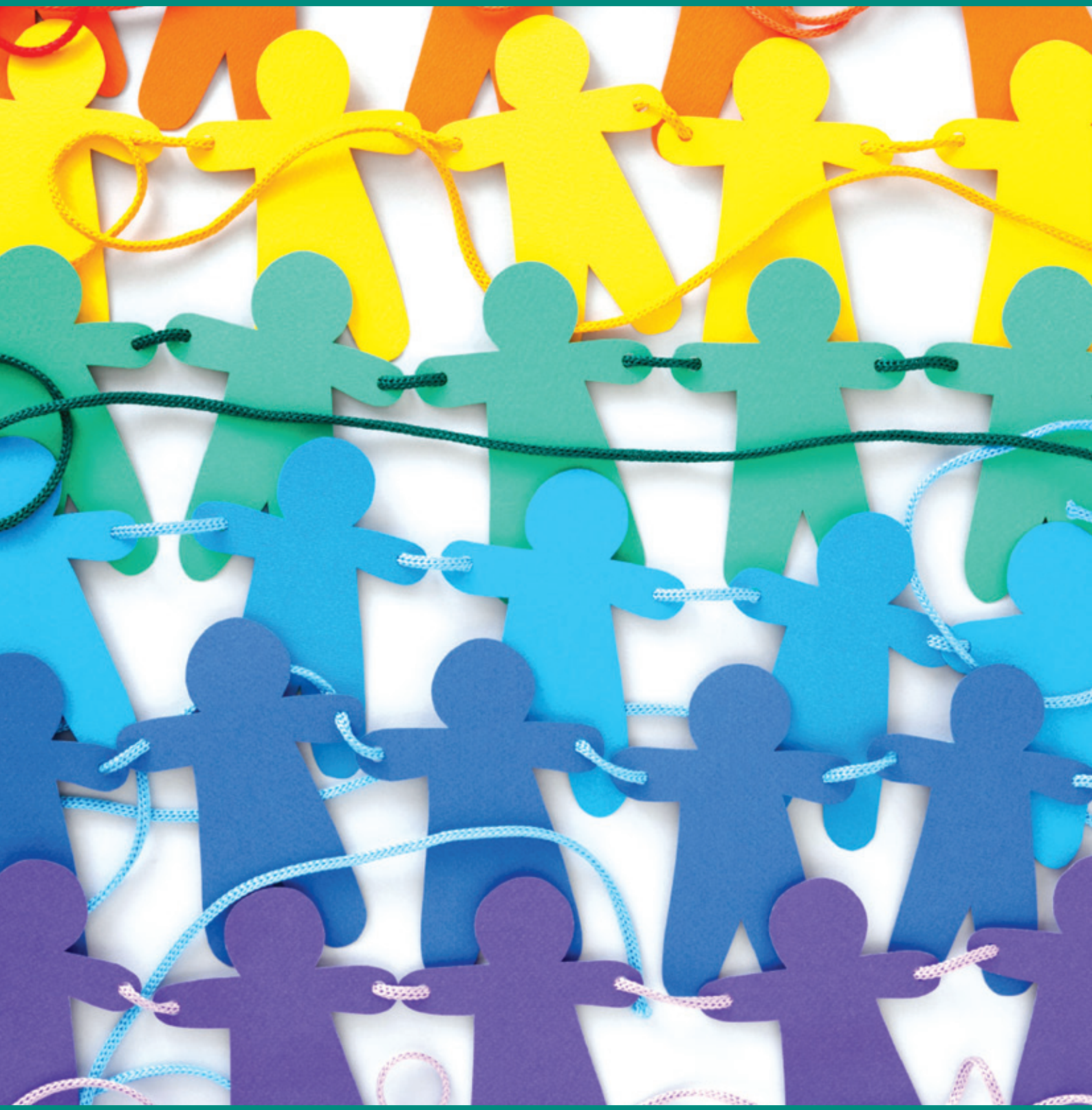

Foreword

One of the Royal Society for Public Health's key priorities is to support the public health workforce – in its broadest possible sense – to improve the public's health. This report looks at just one section of this workforce: those tasked with improving health through their work within a local authority setting in England.

While life expectancy at birth has risen steadily over the last century in the UK (with statistics for England and Wales suggesting it currently sits at around 79.1 years for males and 82.9 years for females),[1] this statistic belies a more concerning trend. Over the same period, health inequality has steadily increased. Those living in the poorest areas can now expect to live on average seven years less than those living in the wealthiest areas; this gap rises to 17 years when considering disability-free life expectancy.[2] The children's charity, World Vision International, places the UK at 22 on the Global Health Gap Index, far behind other Western European states such as France and Germany, who sit comfortably in the top 10.[3] With continuing budgetary constraints across the NHS and local government, health inequalities are set to rise even further.[4] It is vital that effective strategies are put in place to address this issue.

The transition of public health teams in England from the NHS to local authorities has been billed as a key way to address the wider social determinants of health that are at the centre of much health inequality in our society. At the RSPH we are excited about this potential, but acknowledge that getting to a place of whole system working across the health and social care system, along with partnership working across all levels of the local authority poses a challenge for public health.

We hope that this report, through the insights offered, will help support the health improvement workforce on this journey towards reducing health inequalities and improving the public's health, and that as the journey is charted over the coming years, it will provide evidence of the progress that has been made.

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Chief Executive, RSPH
January 2014

References

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3. World Vision. *The Killer Gap: A Global Index of health Inequality for Children.* Chatelaine: World Vision International, 2013.
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Introduction

This report follows on from three previous reports that provided a snapshot of the development of the health improvement workforce in England in 2011, 2012 and 2013 (available at www.rsph.org.uk). These studies highlighted the challenges associated with ensuring that staff have the necessary skills, knowledge and competence to promote health and wellbeing regardless of which setting they work in or who employs them. They argued for the integration of the workforce across public health, the NHS and adult social care as well as the need for making public health improvement 'everyone's business', all of which, we would argue, remain key to improving the public's health. As the 1st April 2013 drew closer, last year's report highlighted the challenges and opportunities posed by the move of public health departments from the NHS into local authorities in England from the workforce's perspective.

Previous reports were all written in anticipation of the move of public health departments into local authorities, and this is the first that can start to question how the vision of localism is working out in practice. This year we have chosen to focus on the public health teams working within local authorities and who have to put the case for investment in health improvement to their local health and wellbeing boards. We seek to undercover whether the opportunities for improving the public's health offered by the transition are being realised, what challenges are being experienced, and also to gain an insight into the current environment for public health within local authorities.

This report draws on data from a series of focus groups held in the last quarter of 2013, along with in depth interviews and a survey of public health professionals working within local authorities across all regions of England (n=261). The respondents included a broad range of the public health workforce, including directors of public health, consultants in public health, public health specialists and health improvement practitioners. One of the clearest conclusions was the heterogeneity of experiences. No two local authority environments are the same, each combining different personalities, cultures, organisational structures and histories. At the same time, common, reoccurring themes were identified. These themes are explored through the body of the report.

The public's health

One of the key aims of this research was to understand how the changes to the public health system are impacting on the public's health from the workforce's perspective. Last year's RSPH Report identified the general move of public health into local authorities as an opportunity for improving health in a locality. However, we found that more than half (52%) of survey respondents for this report were unconvinced about the ability of the move to help reduce health inequalities and improve the public's health in the future, and very few believed that the transition was improving health outcomes already (less than 15%). Interviews suggested that for many areas this reflected the early stage in the transition, with provider contracts often being extended rather than retendered as public health teams bed in, and relationships between public health and other local authority departments continue to develop.

However three quarters of respondents believed that the transition offers new opportunities for engaging with local communities. Interviewees felt that local authorities have historically been much better at consulting and engaging with communities than the NHS, where primary care trusts and within them, public health teams, were located prior to the move. The duty of councils to consult and serve their electorate also offers more co-operative ways of working with the public than are available in the NHS. While only a third of respondents suggested that the public were currently being involved in commissioning processes and decision making on spend, it does suggest that a key future opportunity for many areas will be to further develop co-commissioning models to ensure that public need is being met appropriately.

Local authority environment

Another area the research sought to investigate was the public health workforce's experience of the new local authority environment.

More than half (59%) of survey respondents felt that health decisions within the local authority were being based on political process and decision making rather than purely on the evidence base, whether academic literature or Government statistics (e.g. Health Profiles), (only 15% disagreed with this statement, with the remainder unsure). For some respondents (20%), there remained an issue with accessibility to the evidence needed to argue for investment in health improvement. Interview findings suggested that while evidence was available to argue that investment in public health would have cost benefits to the NHS, less was available to argue for the cost benefits to the local authority. The evidence to support the case for investment in public health to reduce pressure on other local authority services was also very limited at the time of research.

Some respondents highlighted gaps in the knowledge of councillors around health and health improvement, with a third suggesting that councillors did not fully understand the need for health impact to be considered when making decisions about their community, and a similar number suggesting that 'making every contact count' as a concept was not well understood.

This is reflected in the findings that while nearly 90% of respondents stated that they have the professional skills relevant to their new situation within local authorities, over 80% believed that additional influencing skills would be beneficial to help them demonstrate their effectiveness and value within local authorities. This suggests a need for further investment in training and support as well as continued shared learning and insights about what works.

Despite this, most respondents felt that they had sufficient access to relevant decision makers in their authority. This gives an early indication that an engaged discussion about investment in health improvement and related cost benefit analysis of impact across services is starting. This will be further supported as a local evidence base starts to emerge that is of direct relevance to council members and local decision-making protocols. There is a potential benefit therefore in sharing early learning and practice to ensure that the case for investment is built.

Even in the face of this challenge, there was broad agreement that public health teams are framing health improvement in terms of how it can contribute to wider local authority outcomes when in discussion with colleagues in other departments. Over 65% of respondents suggested that their public health department was working closely with other local authority departments, suggesting that the wider determinants of health are being prioritised.

Finances

With cost savings being a priority across most, if not all, local authorities, it was concerning to find that more than half (53%) of respondents suggested that public health budgets are not ring-fenced in practice. Nearly three quarters of respondents suggested, perhaps as a result of this, that financial issues were impacting upon the ability of the public health workforce to plan for and deliver health improvement initiatives locally. This may also be further shaped by the localism agenda – interviewees suggested that where the key local priority is cost saving over the short term, this may conflict with any argument for long term investment in health. It was also highlighted that there is an increasing need for integrated commissioning across the health and social care system and for cost savings to be looked at across the whole system. Without a whole system approach, incentives remain to shift costs elsewhere or not to act at all.

For some services, particularly sexual health, interviewees suggested that the transition had led to a large amount of cross-charging for services between local authorities to ensure that only services for residents were being paid for. There was a concern that spending time on finances was redirecting individuals away from time spent on wider health education initiatives and a more preventative agenda.

However, despite these concerns, the majority of respondents highlighted that investment is continuing to be made in health improvement initiatives, including 'making every contact count' and health champions. Supporting council members and staff from across services to understand the ongoing impact of this work will be key to ensuring that these initiatives continue to receive investment.

Health and wellbeing boards

Health and wellbeing boards (HWBs) were set up to bring together key commissioners from the local NHS and local government, including directors of public health, to strategically plan local health and social care services. It was envisaged that they would provide a forum where key leaders from across the health and social care system could come together to agree how best to improve the health of their communities in a collaborative and joined-up way.

This research sought to understand how they were developing in practice. Our survey uncovered differences in views across the country about the importance of the local HWB for influencing commissioning decisions and there was also no consensus about whether HWBs are the best place to debate local need and evidence. Interviews suggested that the development of health and wellbeing boards are at different stages across different localities and that a range of different models are being adopted, with some boards focussing on becoming commissioning bodies themselves, and others focussing on providing strategic direction for others.

While some boards are already pooling budgets across social care, children's services and the NHS, others are not, highlighting that integration is further ahead in some areas than others. Furthermore, while in some areas boards appear to be viewed as key for partnership working and cross checking across disciplines and responsibilities, for others they are being seen as a bureaucratic exercise. These differences are likely to reflect the individuals on the HWBs as well as their size and organisational cultures. It is also being found in some areas that big agenda items like health and social care integration are being prioritised by boards, resulting in other public health issues needing to be addressed through other avenues. Over time, it will become clear whether they can fulfil their original mandate, and it appears likely that some areas will be more successful than others.

Conclusion

This report highlights that the public health workforce within local authorities in England are continuing to bed in following the official shift from the NHS on 1st April 2013. While for some teams with a history of working closely with the local authority this transition has been relatively painless, for others, this has been a time of far reaching cultural and systems change.

There is genuine optimism about how the transition will provide opportunities for greater community engagement in health and commissioning decisions, and this is very encouraging to see. At the same time there remain concerns about how public health will fare as councils face further budget reductions and how money ringfenced for public health is being allocated in practice. Health and wellbeing boards are still developing but there remains ambiguity about their ability to influence commissioning and provide a forum for collaboration.

Finally a key finding is the concern expressed by public health professionals over the perceived role of politics in health decisions being made within the local authority environment. There is an opportunity for more shared learning about emerging practice and training needs as they relate to the influencing and engagement roles of public health teams, as well as how council services can support the integration of health improvement into their service provision and outcomes. There is also an opportunity to build the evidence base to influence investment decisions and to support council members in increasing their awareness of the potential impact and benefits of frameworks such as 'making every contact count'.

We are aware that the health improvement landscape will look very different again in a year's time and we are looking forward to reporting again in 2015. The Royal Society for Public Health is committed to supporting shared learning to build capabilities across the system to make good decisions that impact on improving health and wellbeing for all our communities.

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Anyone wishing to contribute to our annual workforce survey for 2014/5, please contact Caitlyn Donaldson, cdonaldson@rsph.org.uk