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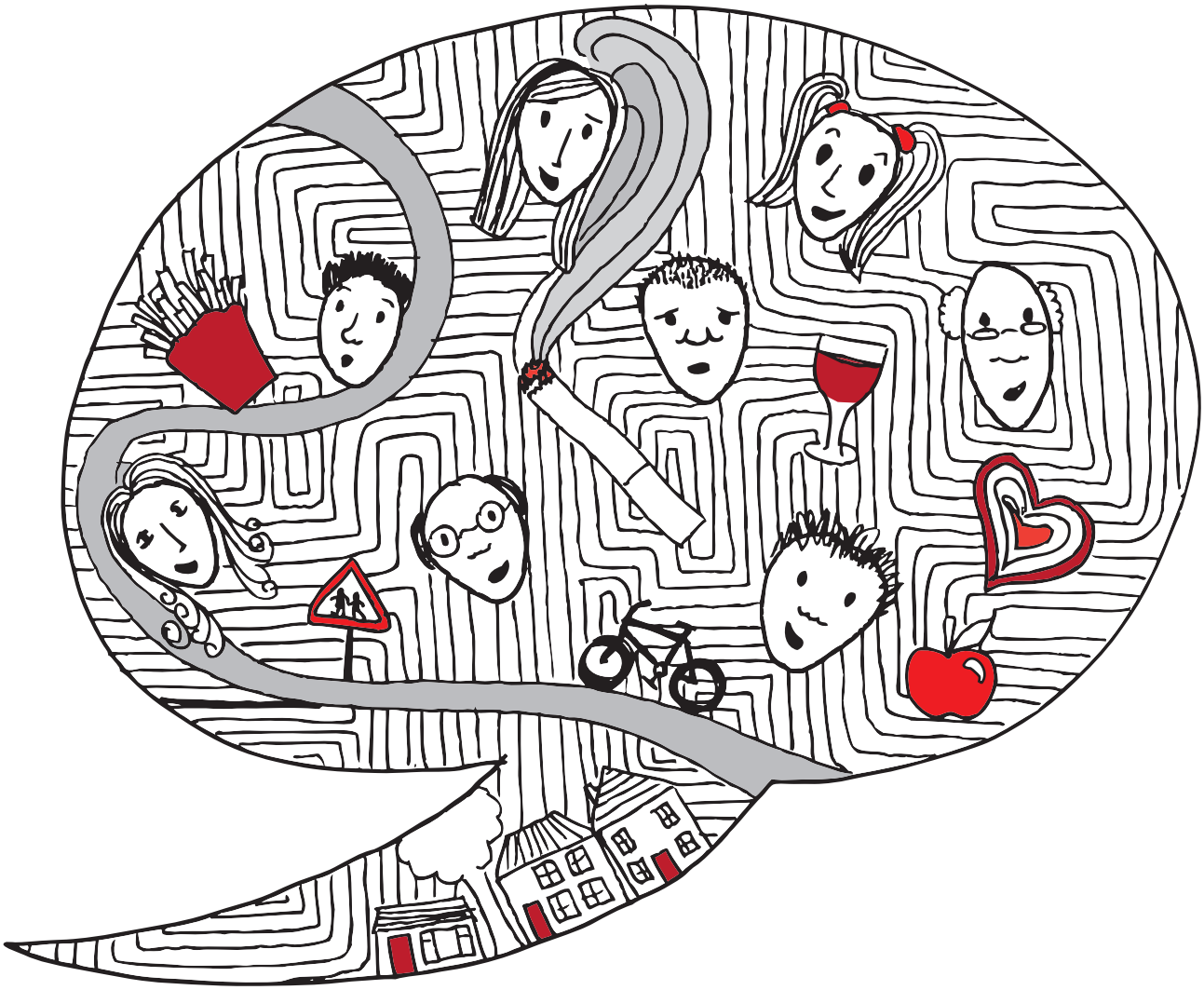
NLGN DIALOGUE SERIES



HEALTHY DIALOGUES
ROUNDTABLE WRITE-UP

SARAH STOPFORTH

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FUNDED BY

sanofi pasteur MSD

INTRODUCTION

It is now eighteen months on from the transfer of public health from the NHS to local authorities, and one year on from the publication of the NLGN report Healthy Dialogues: Embedding Health in Local Government. To mark this, NLGN hosted a roundtable to consider the transition so far and how issues have moved forward since the publication of the report. Participants in the discussion included local authority Chief Executives, Councillors, Directors of Public Health and academics. The key questions for this event were designed to explore the extent to which public health has embedded into local government; the ongoing challenges that areas are experiencing and what this means for how local authorities have to work moving forward. This paper outlines the key discussion points and themes that emerged during the event.

THE TRANSITION SO FAR

The transition of public health from the NHS to local government was always expected to be complicated. The NLGN report, *Healthy Dialogues*, published six months after the initial transfer, identified two key stumbling blocks during the transition: structural and cultural differences.

Many health practitioners believed that it made sense structurally for public health services to fall under the remit of local authorities; however, in practice the re-structuring of departments and responsibilities proved logistically difficult. For instance in two tier areas, public health sits within upper tier authorities, but clearly the work of district councils has an impact on the health and wellbeing of an area. Structurally, this requires representatives from districts to sit on Health and Wellbeing Boards, however this presents quite practical challenges.

Culturally, the amalgamation of public health teams and local authorities has caused some tensions, especially as public health teams are no longer accountable to the NHS and central government, but accountable to the members of local authorities and the electorate. In particular for Directors of Public Health, their changing role has been a difficult transition. As of yet, some of these problems are still to be completely ironed out.

Fortunately, the mood amongst the members of the roundtable discussion was remarkably positive and the general consensus was that the new system was largely working. Although the transition was challenging for managers and operational staff, on the whole it has been a positive and successful transition and good work has been taken forward. In particular, it was noted that although the change has been challenging - with greater scrutiny of spending decisions, budgeting and value for money - this has resulted in more efficient and effective services that

are starting to address broader health and wellbeing outcomes.

KEY THEMES

A number of key themes emerged from the discussion around structure, culture, collaboration and finance. Some operational issues of financing and staffing still need to be resolved and there needs to be greater collaboration and integration across council departments and with the NHS and voluntary and community sectors in order to deliver effective public health services. In many ways, these problems should be resolved within individual authorities as public health further beds down, Quite simply, this will just take time and sweeping recommendations for further top-down reform are not necessary. However, as the debate moves towards greater engagement with various stakeholders around health and wellbeing and how to achieve this at whole-place level, collaboration and integration become very important. This will require some local structural and cultural changes.

STAFFING

Many of the problems surrounding the transition of public health teams from the NHS to local authorities have centred on the tensions created by what is a significant structural change, not least in relation to the physical transition of teams from one institution to another. In terms of management structures, at present 43% of Directors of Public Health report to local authority Chief Executives, creating questions regarding leadership on public health. Having Directors of Public Health sitting outside of the local authority leadership tier suggests that public health isn't necessarily a central priority for some councils and this can create tensions. A key recommendation from the discussion was the importance of parity of status of Directors of Public Health with directors of other departments.

In terms of financing and staffing, delegates felt that it is troubling that some staff have been systematically disadvantaged by the integration of pay scales of public health teams within local authorities, especially where this involved a pay cut. Additionally, in some circumstances, line managers are being paid less than the staff who report to them, which will be a sticking point for organisational morale and has severe consequences for recruitment. This seems like a transactional issue which should be resolved as public health teams become more embedded in local authorities and issues of pay scales and organisational finances align. Unfortunately for those involved, it was felt that this may be a case of having to 'grin and bear it' as the transitional phase comes to a close.

The main question moving forward, and which will need to be revisited, seems to be whether these staffing issues are short-term and will sort themselves out over time, or whether

they represent more deep-rooted structural and cultural problems, which will persist far beyond the initial transition phase.

INFORMATION SHARING

One of the driving forces behind the transition of public health services from the NHS to local authorities was the capacity to concentrate on the local agenda. Through prioritising local need, public health budgets and resources can be targeted towards the most prevalent health issues within any given area. In theory, this could greatly facilitate a move towards prevention and early intervention and long-term financial cost savings which would be in the best interests of a wide variety of stakeholders across local government departments.

However, one of the greatest obstacles to this has been accessing NHS data sets that public health teams had access to when based within the NHS in order to combine them with the data held by the local authority. This has made the change much more difficult to coordinate, particularly in relation to the role of the new Directors of Public Health. Public Health England is working with the Department of Health to clarify how the existing law can provide a legal basis for local authority access to patient-confidential data for defined public health purposes.

FINANCING

A surprising finding was the persistence of challenges in relation to ring-fenced budgets. Ring-fenced budgets for public health have been highly contentious. Some senior officials believe they are a luxury when local authorities are expected to cut-back so much, whereas others have expressed relief at ring-fenced budgets for under-resourced issues like substance misuse or mental health, which might struggle to find funding otherwise.

Negotiating how the budgets are allocated and who bears risk associated with the allocated budget is also a challenge – particularly as ownership of ring-fenced budgets appears to be another tricky process of negotiation. In the original research report, one Director of Public Health commented that “People wanting to get their hands on *our* money is one of the biggest difficulties” (emphasis added). The participants in the roundtable discussion confirmed that tensions around ownership of the budget persist, with a distinct ‘us’ versus ‘them’ approach. Risk- and resource-sharing becomes a lot more difficult to navigate when fundamental conflicts exist. In turn this creates key stumbling blocks for the facilitation of collaboration and integration.

An important point raised during the discussion was the challenge of local authorities engaging with the NHS around focussing budgets towards prevention and

early intervention. Local authorities, in the midst of austerity measures and squeezed budgets, are motivated by preventing acute health problems due to the long-term financial consequences. However, financial incentives within the two sectors do not align, and this makes shifting money around the two systems and towards prevention challenging. Ironing out fundamental tensions in incentives is highly important, but very complicated given the current way in which finances are devolved from central government.

Problems of aligning central health priorities with local authority political priorities and allocating budgets to complement this is a cultural by-product of the transition which may not easily be resolved. However, as public health in local government becomes a norm rather than a novelty, and as contracts are re-commissioned and priorities identified, this problem should ease over time.

INTEGRATION

Re-locating public health teams from the NHS to local authorities has been a huge transformational change and has required the cooperation, collaboration and integration of a variety of stakeholders. This has especially been the case for public health teams who have to navigate austerity measures, increasingly scarce resources in local government and rising demand in some key health outcome areas. As the debate regarding public health moves on from transition to engagement and greater transformation, another major theme emerging from the discussion was that of collaboration and integration across different council departments and between different parts of the public sector and external stakeholders.

It is no longer possible to talk about public health in isolation from other council departments. Integration emerges as a vital component of resolving challenges of resourcing, managing demand and shifting towards a more preventative and community-based health system. Through forging long-lasting relationships between council departments, the NHS and the voluntary and community sector, these issues can be addressed and adapted to a local agenda. For example, Leicestershire County Council has implemented a collaboration between health and housing departments by implementing a preventative agenda. Through engaging stakeholders within various council departments as well as in the voluntary sector, top-down and bottom-up dialogues are facilitated with multiple resources available to help to roll-out initiatives. In Hounslow, there are two main health priorities: TB and diabetes. Focusing resources on these specific local issues has been fundamental to stretching scarce resources, which has required a collaborative approach between council departments in order to fully commit to the mutual objective of prevention.

Participants noted that Health and Wellbeing Boards are important facilitators for integration and collaboration; however, the challenge is that these boards are not uniform and do not always deliver on priorities. Questions were raised about how transformational Health and Wellbeing Boards can be. Currently there is a tendency for them to engage in a transactional fashion, and there are questions regarding whether the right people are around the table to work well at a strategic level.

This seems to be a particular issue in two-tier areas. Delegates suggested that a practical solution to the barriers to collaboration is to involve Directors of Public Health and all relevant stakeholders in the board's conversations held about public health. Health and Wellbeing Boards might need to expand beyond the inclusion of councillors, Clinical Commissioning Groups, and Directors of Public Health to involve a wider-range of stakeholders. Although this, of course, needs to be balanced with the need to keep a strategic focus and not have so many members that decision making becomes too difficult. Either way, communication is key to the facilitation of collaboration.

CONCLUSIONS AND NEXT STEPS

Although the debate has moved on and the transition of public health from the NHS to local authorities has generally been considered a success, some problems still persist in the transfer of powers and responsibilities. As such, many of the recommendations from the original NLGN report on the transition of public health to local authorities remain relevant eighteen months on:

- Stronger leadership is needed to create horizontal networks;
- Space needs to be created for councils to innovate;
- Co-design of services should occur with the community; and
- Continuous evolution of relationships, contracts and services is essential.

Although there are operational problems in moving from the transition phase to full integration of public health across sectors, there is much positivity to be taken from the journey thus far.

Moving forward, time will need to be spent developing the relationships required to gain the full cooperation of the NHS in operationalising public health services and focussing on strategic health and wellbeing for the long term. Eighteen months on from the handover and one year on from the NLGN report, the transition is almost complete. However, the ongoing challenges of setting priorities, finances, and engaging internal and external stakeholders may take more time to resolve. More attention to collaboration and engagement of a wider variety of stakeholders may help to pursue the local agenda for early intervention and preventative measures in public health whilst minimising the resource and budgetary pressures on local authorities.

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