LGA response to DHSC call for evidence on local authority public health prescribed activity

16 April 2018

Submission

About the LGA

The LGA is the national voice of local government. We work with councils to support, promote and improve local government.

We are a politically-led, cross-party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils, so they are able to deliver local solutions to national problems.

Introduction

1.1 We welcome the Government's continued support for the devolution of public health responsibility and power to local authorities, allowing local services to be shaped to meet local needs must continue to be the core principle of the reforms as outlined in the Health and Social Care Act 2012.

1.2 Local authorities continue to make progress on improving health and wellbeing and tackling health inequalities since public health was formally transferred from the NHS in April 2013. Public health was now settled in local government, with a growing confidence that, even though there was much more to do, councils are taking on responsibility for health and wellbeing across all their functions.

1.3 We have repeatedly warned of the serious consequences of funding pressures facing local services from unprecedented funding reductions since 2010 and growing demand for services.

1.4 Local government is operating within severe financial circumstances. For example, the public health grant has been cut by almost £600 million (nearly 10%) from 2015/16 to 2019/20. Government funding for the Early Intervention Grant has been cut by almost £500m since 2013 and is projected to drop by a further £183m by 2020. The LGA estimates that local government will be faced with a core funding gap of £5.5 billion by 2019/20.

1.5 Any change to the prescribed public health activity should be seen within the financial context that local authorities are having to operate.

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2. What is your view on the principles of prescribed activity? Are they still the right ones? Is there evidence to support your view?

2.1 The LGA accept that a limited number of prescribed services can be useful for protecting public health as part of a broader package of measures. There are a series of services which are ‘business critical’ to local public health, in particular those associated with health protection (the control of infectious outbreaks and emergency preparedness). In some service areas (particularly open access sexual health) greater uniformity of provision is required. In others, the Secretary of State for Health is currently under a legal duty and needs to ensure that his obligations are effectively delivered when a function is delegated to local government (the provision of contraception).

2.2 As the government reduces their funding to local authorities, it is important that the Department of Health and Social Care (DHSC) assess existing current and future health spend rigorously, but they must do so transparently, to ensure local authorities perceive the process as fair. We do not believe that the Government has been sufficiently open about which new burdens are assessed and the outcome of those assessments. It also needs to ensure that spending reviews and annual finance settlements for local government take full account of the many cost pressures local authorities face.

2.3 We believe that any additional prescribed services could hamper local discretion and lead to additional financial burdens for councils. We call on the Government to provide sufficient funding to cover all current and future responsibilities. Leaving councils to pick up the bill for unfunded government policies, at the same time as managing spending reduction and such growing demand for services, is unacceptable.

2.4 The public health ring-fence should not be considered as a significant assurance framework, given that it has been cut significantly by the government over recent years and will continue to do so in the future. We should not see an end of the ring-fence and the potential move to Business Rates Retention in 2019/2020 as a cue to put in place more controls. The vast majority of councils care deeply about public health services and outcomes for their residents, it would be wrong to design a new model that starts from a deficit model of one of mistrust and control.

2.5 Local authorities do need to be given more leeway to deliver on local public health outcomes. Therefore, prescription should be reduced - outside those services that require a significant degree of uniformity as we have outlined above. The key priority for local authorities is a focus on a place based model that shapes and improves health outcomes and therefore it is questionable what the role of mandation plays in achieving that.

2.6 The LGA believes that DHSC needs to use intelligence from the New Burdens regime better, to improve its understanding of pressures affecting local authorities’ financial sustainability. Even

though many new burdens are small, their cumulative impact matters and this should be considered when government sets local authority funding.

2.7 There is a risk, that as cuts to the public health grant start to impact, government comes under increasing pressure from colleagues across Whitehall and the various public health disease specific interest groups to protect their particular areas of concern. So far, DHSC have resisted attempts to tie the hands of local authorities further through additional mandation and prescription. From a practical perspective, local authorities report that they could not afford any further mandated services as they are already having to reduce their discretionary spend due to the grant reduction.

2.8 There are a range of public health services (for example: tobacco control, weight management, behavioural and lifestyle campaigns) that we believe the commissioning of these services should remain as discretionary, but guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy. We believe that we should avoid designing a system that protects particular providers and service models which has the potential to stifle innovation.

2.9 Local authorities have increasingly developed integrated lifestyle services which will provide people with all their lifestyle support through one single point of access, rather than through separate services. Stop smoking, weight management, alcohol reduction and physical activity support, which were previously provided separately, are now provided through one integrated service. The services take a flexible, person-centred approach and provide behavioural advice and support to people across a range of different behaviours.

3. Substance misuse

3.1 Between 2013/14 and 2017/18 local authorities would have spent over £3.8bn on drug and alcohol treatment and prevention. Overall, 279,793 individuals were in contact with drug and alcohol services in 2016-17. Nearly all individuals (98%) waited three weeks or less from first being identified as having a treatment need to being offered an appointment to start an intervention, with 82% of first interventions having zero days waiting time.

3.2 We believe there is some merit in strengthening the current requirements surrounding substance misuse. Similar to the arguments for retaining the mandation around sexual health and health protection, substance misuse does not respect local authority boundaries and residents in need of support should be able to have access to comprehensive, open access treatment services for substance misuse.

3.3 Alcohol Treatment Services have historically started from a poorer base, relative to drug services and need to be supported with additional ‘new burdens’ investment.

4. Weighing and measuring children

4.1 Since councils took over the delivery of the National Child Measurement Programme (NCMP) from the NHS in April 2013, coverage has significantly increased. Last year 1,185,811 children (reception and year 6 combined) were weighed and measured, this represents more children being weighed and measured than any previous year since the programme was first established. Councils spent £20.2m delivering the NCMP last year around £1.3m less than the previous year. Since 2013/14 Councils would have spent over £100m on delivering the NCMP.

4.2 Local authorities already provide data to government departments on their spending and performance, via several data sets contained in the Single Data List. The Single Data List contains the entirety of central government departments' data requirements from local government, which means that councils know exactly what information Government will ask for over the course of the year. As NCMP is on the Single Data List we believe it does not need to be mandated, as it does seem a bit ‘belt and braces’ to have both.

4.3 Councils have demonstrated their commitment to tackling childhood obesity but they need the flexibility to spend their public health budgets in a way that delivers initiatives that suit the needs of their local communities.

4.4 With council public health budgets being cut, there is a real risk that councils will not have the resources to fund lifestyle and weight management programmes that parents have come to rely upon. So we call on the DHSC to explore whether it could be achieved more cost effectively through the use of sampling.

5. NHS Healthcheck assessments

5.1 Local authorities have done a tremendous job in inviting more than 12 million eligible people to have a check over the past ¬five years – of which six million have taken up the offer. There is concern around the evidence of effectiveness and cost effectiveness of the health checks programme, the implications for population level approaches and the potential impact on health inequality.

5.2 Pressures on local authority public health budgets, make it increasingly difficult to maintain the government’s commitment that 20% of the eligible 40-74-year-old population will be invited to have an NHS Healthcheck every year. Public Health England estimate that 1.4 million people who are eligible to have a Healthcheck will not have been offered one by the end of this current five-year cycle.

5.3 Local authorities will have spent £296m on the NHS Healthcheck Programme between 2013/14 and 2017/18.

5.4 Without sufficient funding to maintain the NHS Healthcheck Programme, there will continue to be calls from some within the public health community to abandon the programme or to convert the NHS health checks programme away from a universal offer towards a systematic primary care programme, which uses risk stratification to identify the people most at risk first and ensures they

get appropriate interventions.

6. Sexual health services

6.1 The LGA supports open access services to genitourinary medicine (GUM), which include LAs making arrangements to cover users from outside their local authority boundary/region. Local authorities will have spent £3.1bn on sexual and reproductive health between 2013/14 and 2017/18.

6.2 The mandated function requires each local authority to provide, or secure the provision of, open access sexual health services in its area including: preventing the spread of sexually transmitted infections (STIs); treating, testing and caring for people with STIs and partner notification.

6.3 Local authorities should provide contraceptive services including advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and advice on preventing unintended pregnancy.

6.4 We acknowledge that sexual health services are different to other mandated services, with the complexity of multiple commissioners responsible for the delivery of an integrated service. We see no reason to change the existing mandation on local authorities.

7. Healthcare public health advice service to CCGs

7.1 There is a statutory duty on upper tier and unitary local authorities to secure provision of a public health advice service to any CCG whose area falls wholly or partly within the authority's area with a view to protecting or improving the health of people in the locality. The current mandate could be strengthened to extend the mandate to the wider health economy for example extended to include advice to NHS Trusts and nationally to NHS England.

7.2 The duty to improve the health and wellbeing and to reduce health inequalities should be across all key players in the public health system – ie Councils, NHSE and PHE. Mandation is system wide not just applied to individual organisations and that approach would fit far better with the development of Integrated Care Systems. We believe this would give some added weight to the population health and prevention aspects of the 5YFV and have the added benefit of making mandatory to embed population health approaches into STPs. We believe it would also avoid a repetition of the arguments between LAs and NHSE over the introduction of interventions such as PrEP, with NHSE arguing that they are not responsible for certain aspects of prevention.

7.3 A wider duty would also allow local authorities to have greater scrutiny and local accountability over the performance and quality of screening and immunisation programmes which are fundamental public health functions which are not currently under local authority direct control.

8. Protecting the health of the local population

8.1 In general there has been good engagement by local authorities with the emergency preparedness work and the establishment of LHRPs co-chaired by directors of public health in all LRF areas. There is variation across the country about how any wider work on this duty has been enacted by local authorities.

8.2 In some areas there are health protection subcommittees of health and wellbeing boards where health protection concerns are reviewed by the director of public health, while in other places more informal arrangements are in place between the director of public health and PHE staff. The mandate to provide information and advice to relevant organisations to ensure all parties discharge their roles effectively for the protection of the population is exercised predominantly through the work of local authorities as Category 1 responders and developed with other partners of the LRF and LHRP. We see no reason to amend the existing duty on local authorities.

9. Health Visitors

9.1 Local government understands that the early years, particularly a child's early life experiences, parenting, environment and education have a crucial impact on a child's longer term outcomes.

9.2 Councils are committed to reducing inequalities in children and families. The universal health visiting service plays a vital role in laying the foundations for lifelong health and wellbeing and tackling inequalities. Since health visitor commissioning transferred to local government in October 2015, councils have demonstrated their commitment to transforming and integrating the service with the 5-19 Healthy Child Programme and to meeting the five mandated elements of the 0-5 Healthy Child Programme despite funding being reduced.

9.3 At the point of transfer in October 2015, the Department of Health recognised that the delivery of the five mandated health visitor checks, which were at that time delivered by the NHS 'was not currently at 100 per cent'. Since councils took over they have increased the number of contacts.

9.4 Councils need flexibility to meet the public health needs and priorities of their local communities. Whilst the current five mandated checks provide an assurance for a universal service they are rigid and do not reflect local priorities. This poses a risk of a tick box exercise and does not enable responsive services to be developed according to local need.

9.5 Health Visitors flexibility is needed around skill mix, such as having the option to use the wider workforce such as early help workers and children's centre staff flexibly to deliver the 0-5 Healthy Child Programme. This will not only help to reach out to those families and children that are at risk or facing the greatest inequalities but will also relieve the pressure on health visitors. It is right that health visitors are the leaders of the 0-5 healthy child programme but with councils operating in financially constrained times local flexibility

and a variety of delivery models is needed.

9.6 The health visiting service needs to be fully funded. The Department of Health originally promised that any variances in historic resource allocation at the point of transfer of 0-5 health visiting services would be resolved via the introduction of a resource allocation formula. However, this was not introduced, which has resulted in some local authorities operating with less money for their health visiting service. We would like to see this rectified.

9.7 Councils are clear that additional mandated health visitor checks would restrict local flexibility. Whilst the LGA does not advocate additional mandated checks it is imperative there is a robust evidence base for any new checks. We remain clear that mandation must only be based on improving outcomes for children and families and must not be used as a mechanism to maintain workforce numbers.

9.8 Additional mandated health visitor checks would result on a new burden on councils and councils would need to be properly resourced both financially and in terms of workforce. In some areas such as in London, there were recruitment and retention difficulties at the time of the transfer, which are ongoing and is continuing to have an impact on the service locally, this is also a problem for other local areas. A thorough public consultation and the enactment of the new burdens doctrine would be required should the number of mandated checks be increased.

9.9 We remain concerned that the current health visiting workforce cannot cope with the current level of demand and any potential additional checks. Proper consideration needs to be given to whether or not this is realistic and who else in the wider workforce could carry them out. The Institute of Health Visiting survey showed that 1 in 5 health visitors in 2017 are working with caseloads of over 500 children. However, the recommended 'minimum floor' set at the time of transfer was three whole time equivalent health visitors to cover 1000 children.

9.10 Councils are demonstrating a desire to protect children and young people's services and to invest in the "Best start in life". In 2016, analysis of councils financial returns indicated that they had increased public health spend on 5-19 year olds by 8.7% and spend on 0-19 year olds made up the single largest spend from the diminishing ring fenced public health grant. This is resulting in local transformation and integration across 0-19 services and wider council led services.

What evidence are you aware of on the impact of the prescribing activity so far? Is there evidence to suggest the impact of the regulations varies between people or groups? This could relate, for example, to people of different gender, age, ethnicity or sexual orientation

10. We believe other organisations will be submitting more detailed evidence on the impact of current prescribed activities on different

groups.

How, if at all, does the evidence suggest that we could change the regulations prescribing activities to support better public health outcomes -for example, as expressed through the objectives of PHOF to increase healthy life expectancy and reduce differences in life expectancy?

11. We welcome the original aims of the Health Social Care Act 2012 in producing a set of indicators focused on achieving positive health outcomes and reducing inequalities in health rather than on process targets. However, the PHOF has not necessarily facilitated a coordinated and integrated approach to public health, social care and children's services at a local level. While wider determinants feature in this framework, the technical domains of public health are still prominent. We agree with SOLACE colleagues, if public health is to be funded through business rates we would expect the number of indicators to be reduced and for DHSC to support local variation in setting of priorities reflecting local need as illustrated in Joint Strategic Needs Assessments.

11.1 The outcomes framework should provide the broad context within which Health and Wellbeing Boards develop local priorities – it should not be used to 'performance manage' public health.

11.2 The development of three separate but overlapping outcome frameworks for the NHS, public health and adult social care does not reduce the reporting burden for local organisations and does not necessarily facilitate a coordinated and integrated approach to public health, health treatment social care and children's services at a local level. While wider determinants feature in this framework, the technical domains of public health are still prominent.

11.3 A single outcomes framework would have represented a real commitment to a shared approach between local and national government, health, social care and public health to shared outcomes.

11.4 We support the Government's commitment to localism as the only way to make significant progress on setting priorities that are locally appropriate and stem from a rigorous assessment of local needs and assets. We welcome the acknowledgement that, to affect real change, local areas need to determine their own outcomes for health improvement through the health and wellbeing boards. The outcomes framework must support local variation in setting priorities and trajectories that reflect local need as illustrated in the joint strategic needs assessment (JSNA). We remain concerned that the framework will be used to manage local performance and that local priorities will be either undermined or overridden by national imperatives.

11.5 It is important that local areas be given autonomy to allocate their resources according to local priorities. We recognise the thin line between the localism agenda and the need for national priorities to be resourced and addressed. However, allowing local health and

wellbeing boards to select the prioritised indicators for investment would help to steer investment and resources to address inequalities and deliver better outcomes nationally

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