- News: Failure to tackle health inequalities is a false economy, meeting hears (*BMJ* 2013;346:f4236)
- News: Two thirds of local authorities face shortfall in public health budgets despite increased funding (*BMJ* 2013;346:f234)
- Personal view: Life assurance (*BMJ* 2013;346:f3722)

Meet the new masters of public health

Public health bore the brunt of English health reorganisations last year as key parts moved from the NHS into local government—an area more used to housing and road problems than a mass measles outbreak. **Richard Vize** maps what's happened to the old NHS run services.

How is public health run now?

Under the Health and Social Care Act 2012 most public health functions carried out by primary care trusts moved to 152 local authorities—unitary, metropolitan, and county councils and London boroughs. These authorities are responsible for promoting population health and reducing inequalities. Councils now run a diverse range of programmes such as smoking cessation, drug and alcohol services, obesity prevention, and prevention and treatment of violence.

The 2012 act created an executive agency, Public Health England, which is part of the Department of Health rather than NHS England. Its responsibilities include health protection, providing information and data, and developing the workforce. NHS England commissions the national immunisation and routine screening programmes, children's public health services up to the age of 5 years, children's health information systems, public health services for prisons, and sexual assault referral centres.

How is it funded?

At least for the first two years, local government public health funding—around £2.7bn (€3.2bn; $4.2bn) for 2013-14—is ringfenced to ensure it isn't consumed by other council departments facing cuts. Virginia Pearson, director of public health at Devon County Council, points out that the ringfence has a disadvantage: "Working alongside colleagues who are making cuts when you are sitting in a bubble is quite difficult. It could strain relationships . . . It doesn't sit well with being a locally accountable structure."

Are public health directors powerful figures in councils?

The Department of Health guidance on appointing directors of public health says they must be directly accountable to the chief executive. Generally, they are part of the corporate leadership team alongside other directors such as those for the environment and housing. But in a few councils they report to the director of adult social care and are not members of the leadership team.

The post is unusual in two ways. Appointments are made jointly by the council and Public Health England, and directors of public health have an unusual degree of autonomy. Each year they publish an independent assessment of the health of the local population, which effectively critiques their employer's record. They could criticise, for example, the council's decision to risk increasing alcohol misuse by growing the night time economy.

Does working in local government feel different?

According to Jeanelle de Gruchy, director of public health at the London Borough of Haringey, moving from a health organisation to a politically led one with priorities ranging from recycling to housing, is a profound difference. She is struck by how political judgment permeates every decision: "There might be a political angle to a mental health campaign or a social marketing campaign to reach seldom heard groups. You need to be aware of how it plays politically."

That does not mean twisting the evidence to fit the politics: "It is for us to be true to the evidence but to present it effectively and understand where local government is coming from," she says.

She stresses the importance of valuing councillors' expertise in understanding their communities. She compares them to general practitioners—they see a lot of people and are sensitive to local issues.

She aims to build strong relationships across the council to "make the case for early intervention and prevention," so that everyone understands how their service can contribute to improving health.

For Lucy Macleod, joint interim public health director at Norfolk County Council, this means highlighting the threat from obesity, stressing to the council that projections for type 2 diabetes and stroke are "too much to contemplate for the health and social care system."

Mary Black, public health director for the London Borough of Havering, says she aims to "get public health thinking embedded in the local authority view of the world." She highlights the diversity of thinking and working practices compared with the NHS: "Local authorities are like the Galapagos Islands—they have all evolved differently."

Now she is in local government, Black is struck by how little the NHS understands how councils work or the pressure they are under: "I don't think the health service understands what it is like to have your budget slashed.

"There is a huge gap in medical leadership understanding of how local authorities work and how they feed into integrated care pathways."

How do directors of public health decide their priorities?

In primary care trusts, staff looked upwards to the NHS hierarchy. Now, public health directors are focused on local priorities and politics. As de Gruchy puts it: "Public Health England cannot tell us what to do in local government. It can encourage and support us, but ultimately I'm accountable to my council."

Priorities are driven by the joint strategic needs assessment. The NHS and local authorities have had a duty to produce an annual assessment of local health needs since 2007. The work is now undertaken with clinical commissioning groups. Each council's health and wellbeing board —which includes the public health director, clinical commissioning groups, adult and children's social care services, the local Healthwatch (independent consumer champions), and usually voluntary groups and other council services—then agrees a strategy to meet those needs.

But directors are also responsible for providing mandatory services such as sexual health—including testing and treatment (except for HIV), contraception outside of the GP contract, sexual health promotion, and disease prevention—and NHS health checks, as well as delivering the national child measurement

programme, providing public health advice to clinical commissioners, and having plans to protect the public from major emergencies such as epidemics.

How do public health specialists avoid becoming isolated from other doctors?

The separation from the rest of the medical profession heightens the personal and professional need to have contact with other doctors. De Gruchy values the local network of public health specialists, sharing ideas and offering mutual support. According to Pearson, success "depends on the quality of the relationship with clinical commissioning groups and GPs—that is as important as the relationship with local government." Many see local medical committees as a vital link.

GPs are crucial in improving prevention and early diagnosis of illnesses such as coronary heart disease and diabetes, notably by using health checks to identify patients at high risk. Obesity is a powerful example. Macleod says "GPs commission the more intensive clinical end and we do the population end." In North Yorkshire, public health director Lincoln Sargeant has been raising awareness among GPs of the range of clinical pathways for obesity as well as encouraging them to connect patients with local support such as exercise programmes.

Will the changes affect medical careers?

As part of its workforce responsibilities, Public Health England will need to ensure public health remains an integral part of career development. Other doctors need to experience and understand it, while public health doctors need to remain close to other disciplines.

"It is one of the things we have to watch because the reforms have made it more difficult for medics to have a career that covers all the domains; so we must make sure that doctors working in local government are not cut off from other clinical work," says Sargeant.

In the longer term, pressure to keep local government salaries down risks public health directors being relatively poorly paid. There are also lingering concerns about what might happen to pensions.

What can councils do that the NHS couldn't?

Moving the service to local government should enable public health to collaborate with council teams that can influence wider health determinants such as housing and fitness. For example, collaborating with transport and education staff can provide street improvements and encouragement for more children to walk to school.

Councils are closer to the communities suffering the greatest inequalities. Councillors have a detailed understanding of the problems local people face and how best to reach them. That close contact opens up possibilities. Pearson aims to involve everyone from local GPs to "the person who runs the shop or pub," as they can have an important role in rural communities around issues such as preventing loneliness.

Sargeant cites North Yorkshire's healthy child programme—linking routine health work with projects such as support for troubled families and reaching young people with risky behaviour.

Are any clinical services threatened by the move?

Councils are struggling with the practicalities of the long established principle of sexual health services being anonymised—someone can walk into a Newcastle clinic to get tested, say they are from Hampshire, and Newcastle City Council will have to recoup the money from the county.

This is a big issue for services based in city hospitals. As Black puts it: "London hospitals could have to deal with 140 local authorities."

Public health specialist Helen Walters, a trustee of the Terrence Higgins Trust, says: "Local government cannot get its head round the open access nature. There are a lot of teething problems."

With councils under financial pressure there is a risk some will question anonymous access because they object to providing the upfront cash to support people from outside the area. "I'm sure that is the sort of conversation that will happen," says Walters.

Public health doctors perceive a second risk in the unresolved issue of giving their teams access to identifiable patient data. Discussions continue.

Could councils cope with an epidemic?

From the point of view of planning for an emergency, the measles outbreak "could not have come at a better time," says Pearson. Emergency planning is not new to local government—it is an important part of its work touching everything from flooding to terrorism. But a clinical emergency is new territory.

The outbreak highlighted questions such as who pays for an additional nurse to go into a school, a discussion which draws in Public Health England, the local area team of NHS England, and the local authority.

"Measles was a good test for how the new system would work. There was a fair amount of confusion at the beginning as to who was responsible for what. It was very good to thrash it all out," McLeod says.

Black says that if there was an epidemic "there would be a bit of a question mark over what we would do because it is all a bit free-form."

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