

6 North East Lincolnshire – integrating public health with local government

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North East Lincolnshire is a small Unitary Authority covering the towns of Grimsby, Cleethorpes and Immingham. Grimsby has a fishing heritage, with current industries ranging from food production to renewable energy and chemical industries. Cleethorpes is a seaside resort and Immingham is the largest port in the country. Health is poor with considerable deprivation and long-standing and wide inequalities in a range of public health indicators. This was a major driver for these changes. Improvements in these indicators are beginning, but we expect it to take a number of years to close the gaps with national rates.

A jointly funded, jointly appointed Executive Director of Public Health post was established early in 2007, and in September of that year a unique organisation came into being, North East Lincolnshire Care Trust Plus (CTP). This is a Care Trust, where social care commissioning is delegated to the former PCT, with two additional elements – the 'Plus'. These are the delegation of children's health commissioning to the council and delegation of the CTP health improvement responsibilities to the council to sit alongside its well-being powers. In order to deliver this the entire public health directorate, around 80 whole time equivalents, is seconded to the council, although staff work back into the CTP to continue to deliver health protection services and the support needed for commissioning health and social care, such as needs assessment and effectiveness work.

This arrangement has given us the opportunity to give a substantial Public Health input in priority setting in the council. Previously the council had no health priorities. It now has just four strategic aims and one of those is 'to improve health and well-being' which includes reducing health inequalities. The other three strategic aims all support the wider determinants of health: economic development, physical regeneration, housing and community safety.

We have also been able to make some specific commitments to work with some teams of colleagues in the council to give a Public Health input to their work. This is the 'added value' of our arrangement and has included support to:

- the strategic housing team to include health impacts

and outcomes in their considerations by undertaking an integrated impact assessment on the East Marsh Neighbourhood Renewal Area

- regeneration, where a joint health impact assessment of the regeneration strategy has resulted in the identification of many actions which can be adapted to give added health value.

Similar work and benefits have occurred with teenage pregnancy, tobacco control and active recreation. For example, a GP physical activity referral programme, working with Leisure and Recreation and service providers, has already seen 247 referrals since 1 April 2009 with a 68 per cent retention rate at ten weeks. Last year was an excellent result; this year looks even better. Other joint working between public health staff and other council staff has seen around 2000 people begin or increase their physical activity this year.

The other 'added value' relates to existing public health programmes, which have been given a boost by being able to access council staff, resources and contacts. Our smoking quit rate is a good example of this, where following several years of failure to meet targets, working with colleagues has contributed to a position where quits are at 160 per cent of target, the success rate for those using the service is 61 per cent compared with the national average of 50 per cent and quits are significantly higher in areas of deprivation.

As someone who has worked very closely with local authorities over several decades, this has proved to be a challenging experience. The culture shock has been huge. Although I thought I understood the role and influence of elected members, I discovered that I didn't really! Their involvement and the way in which the organisation runs is so completely different from the NHS that a whole new approach to using influencing skills is required. Approaches that worked well from outside the organisation need to be reconsidered, not just refined. Informal work seems to be critical.

The second huge challenge for a joint DPH is workload. The DPH role is extensive anyway, with a range of expert

functions, a substantial input into partnership working, a big set of responsibilities as a senior clinician and often additional corporate responsibilities, such as infection control. Carrying two corporate workloads adds to this, with many meetings not directly related to the professional role. I have experienced a great deal of understanding from my Chief Executives, although not always from others. The dilemma is that it is not always possible to anticipate when an opportunity for a public health input will arise. High quality, flexible senior public health colleagues are essential to success here.

A potential for difficulty arises because of the need to maintain organisational confidentiality while at the same time being expected to act as a conduit between two organisations. Discretion, transparency and occasionally stepping backwards are required here. The need for formal mechanisms can't be stressed too much but the opportunity for delicately suggesting an informal word between colleagues is not to be missed.

A final word of caution relates to the time it takes for these major changes to be understood and embedded. We still find people who don't understand the changes and many who have not been able to think through the implications of our new ways of working. This is despite opportunities to find out and explore what we are trying to do. The danger is that health and well-being improvement opportunities are being missed.

Joint Public Health arrangements can take many forms. What is right in one place will not necessarily help elsewhere but the issues of culture, workload and achieving the best from the arrangements will be common to all.