Executive Summary

Aims

The aim of the study was to evaluate the impact of the public health reforms set in motion by the Health and Social Care Act 2012. In three workstreams that reflected new public health responsibilities, we addressed the following objectives:

1. To determine how local authorities used their public health ring-fenced budgets;
2. To identify changes in how preventive services were commissioned and provided;
3. To investigate the leadership role of local authorities in promoting health and tackling health inequalities.

Innovation and health inequalities were cross-cutting themes, addressed through all workstreams.

Background

Implemented in April 2013, the reforms gave local authorities in England new responsibilities for improving the health of their populations, accompanied by the transfer from the NHS of Directors of Public Health (DsPH) and their teams along with a ring-fenced public health grant. The shift reflected local authorities' influence over social determinants of health, their links with local populations and community networks and the benefits of local democratic accountability.

Methods

This 30-month study used mixed methods in all three workstreams. A scoping phase involved interviews with 11 national stakeholders. We conducted four national surveys: two of DPH and Clinical Commissioning Group (CCG) members of Health and Wellbeing Boards (HWBs) (n=39 (2015) and 36 (2016)), carried out one year apart; one of Healthwatch and Voluntary, Community and Social Enterprise (VCSE) members of HWBs (n=34); and one of VCSE organisations involved in health promotion and prevention (n=39). Extensive fieldwork was carried out in 10 case study sites, selected to reflect geographical distribution, levels of disadvantage, authorities in both single-tier and two-tier areas and political control. We interviewed 111 participants in two phases of fieldwork, carried out one year apart. Interviewees included Elected Members, local authority Chief Executives and Executive Directors, DsPH, CCG members of HWBs, Healthwatch and representatives of the VCSE sector. We also undertook documentary analysis. Regression analyses investigated the relationship between public health spend and intermediate outcomes for (a) NHS Health Checks and (b) childhood obesity.

Patient and Public Involvement (PPI)

The study involved representatives of the public in key stages of the research cycle, including identifying and prioritising research topics during a scoping phase, designing and managing the research, analysing and interpreting results and dissemination of findings. These activities were facilitated through the PPI lead on the project team and VCSE representation on the project External Advisory Group.

Equality and Diversity

Equality and diversity were reflected in the PPI strategy and in interview and survey questions. The study investigated how commissioning of preventive services reflects diversity of local populations and VCSE sector engagement with commissioners and public health teams. The case study sites were selected to reflect a range of factors such as deprivation, rurality, ethnicity and political affiliation.

Key findings

Both fieldwork and survey data reflected great variation in how the reforms were being implemented. Key findings are presented for each workstream supplemented by a table summarising perceived positive impacts of the reforms and areas where impacts were below what

might have been anticipated. The table also identifies emergent themes reflecting shifts in perspective that may affect the future direction of public health activity.

Workstream 1: the public health ring-fenced budget

The public health budget was aligned with local authority priorities and often used to fund local authority services where cuts could have a health impact. While DPH control over the budget varied across sites, the importance of the totality of the local authority budget for improving health was increasingly emphasised. By the second phase, in-year cuts to the public health budget, combined with wider cuts to local authorities, were reported as leading to reductions in lifestyle services, public health staff and reduced funding from County Councils for public health activity in District Councils. With the important exception of most local authority executive and service directors, most interviewees, including Elected Members, favoured keeping the ring fence, despite its limitations, to protect public health services and promote accountability.

The evidence base underpinning the choice of mandated services was questioned and in most case study sites there were plans to further reduce non-mandated services, such as smoking cessation. It was argued that mandated services needed to be refreshed, their status clarified and minimum requirements specified.

Regression analyses of local authority level data suggested that higher spend increases the numbers invited to and attending health checks. Uptake rates were unrelated to level of spend, but could be improved by opportunistic activity. In the case of childhood obesity, we found no relationship between spend and obesity levels, but there was a strong positive association between levels of obesity in 2013/14 and those in 2015/16. As these measures relate to entirely different sets of pupils, this confirms that area-level factors are important for explaining levels of childhood obesity.

The public health ring-fenced budget		
Positive impacts	**Impacts less than anticipated**	**Shifts in perspective/future directions**
Greater transparency than for NHS preventive spend; promotes accountability Ring fence is useful in transition period Favoured as protective by most DsPH, VCSE sector interviewees and Elected Members Catalyst for considering PH outcomes across LA directorates and for preventive initiatives in VCSE organisations and CCGs Increase in PH funding in areas where former Primary Care Trust funding was low Reflects variation across LAs in spend in relation to need	Unexpected in-year and ongoing cuts to PH budget Does not reflect PH spend across the LA; unclear what should be included under some reporting categories; large 'Miscellaneous' category Can be easily rebadged or realigned with statutory LA commitments and priorities (especially needs of children and vulnerable adults) and to protect LA services with a health impact from cuts Mandated services need refreshing; non-mandated services were at risk Limited discussion of PH budget or of priority-setting across PH budget categories in HWBs/ Scrutiny Committees; assessment of costs and benefits of realignment across directorates is limited	PH budget considered in light of wider LA commissioning priorities Directorates where PH teams are located can influence PH budget deployment Relevance for PH of the totality of the LA resource increasingly emphasised Risk that public health will be further marginalised if the ring fence is removed / functions are no longer mandated Possibility that deployment of the PH budget will no longer be a means for identifying how limited resources can best be used to tackle upward trends in obesity, increasing multi-morbidity and health inequalities

LA: local authority; PH: public health

Workstream 2: Commissioning and providing preventive services

Perceived benefits of local authority procurement processes included efficiencies, detailed contract specifications (including for social outcomes), greater targeting, use of incentives, more outsourcing and a wider diversity of providers being commissioned through regular review and re-procurement.

By second phase fieldwork, tendering processes were increasingly brought together in a single commissioning facility for the local authority. Most sites had re-commissioned substantial areas of spend (sexual health services and drug and alcohol services) and had re-commissioned, or were in the process of re-commissioning, healthy lifestyle services. The latter were increasingly integrated, bringing together under one contract a wide range of services previously provided separately. Some services had been de-commissioned.

As preventive services were re-commissioned they often incorporated a social model, peer-based approaches to behavioural change, social prescribing and greater responsiveness to community needs and experience. Services were increasingly targeted and integrated with other local authority services. Some interviewees reported improved access to services for sexual health and successful outreach for health checks. There was greater emphasis on co-design, drawing on established local authority engagement processes.

Contracts often favoured larger VCSE organisations. Not all HWBs included VCSE sector representatives and some sites favoured direct support for community development initiatives with less emphasis on the role of the VCSE sector.

Interviewees from most sites emphasised the importance of building community capacity and encouraging communities to 'help themselves', variously linked to demand management, innovation and developing community resilience.

In some sites, concern was expressed over fragmentation in commissioning functions, the 'fracturing' of some preventive services, such as vaccination of school age children and sexual health services and reduced capacity for health protection.

Levels of engagement with the NHS Health Checks Programme varied. At one end of the spectrum was a combination of GP provision, extensive outreach services and integration with healthy lifestyle services. At the other was scepticism about the programme's value for money and effectiveness in reducing inequalities, combined with implementation challenges due to attrition from GPs and restricted provision of follow-on services. The study also identified different approaches to childhood obesity. There was scepticism over the robustness of the evidence base and the effectiveness of local action in the absence of changes in national policy.

Commissioning and providing preventive services		
Positive impacts	**Impacts less than anticipated**	**Shifts in perspective/future directions**
Examples of re-commissioned preventive services leading to efficiencies and innovation; formal scrutiny of business cases Benefits from LA commissioning expertise, infrastructure and single LA commissioning facility Community-based models and co-design more evident as preventive services are re-commissioned, although less change post reforms	Concomitant austerity and cuts to LA and PH budgets led to reductions in traditional lifestyle services Less emphasis on healthcare public health, with less support to CCGs, including for their role in reducing health inequalities Some scepticism over health checks and attrition in GP support Fragmentation in commissioning of	Priorities shaped by Elected Members Traditional PH services are prioritised in the context of LA commissioning priorities and wider strategic role Increased targeting, including for universal services, e.g. health visiting More emphasis on social outcomes and on Social Return on Investment; broader approaches to assessing cost-effectiveness for PH services

than anticipated PH teams build on LA engagement mechanisms and expertise in co-design Unhealthy behaviours considered holistically and in their social context. Less emphasis on single interventions and more on family/community perspectives; healthy lifestyles being considered across directorates Integrated wellbeing services being developed, sometimes including health checks and sometimes part of integrated health and social care services/hubs	preventive services; data sharing more difficult with less access to NHS data by PH professionals National support required for local action on childhood obesity to be effective VCSE not represented in all HWBs; engagement with smaller VCSE organisations variable as was the influence of the Social Value Act on commissioning; variation across sites in VCSE sector influence on commissioning or whether commissioned to provide preventive services	Moving away from single service provision towards integration with existing services (e.g. for children) and for health and wellbeing services; and from commissioning public health services to promoting community wellbeing Asset-based community development approaches promoted across most sites; emphasis on peer support and volunteering; place-based approaches to health and community wellbeing Synergies developing across PH and other LA services; social perspectives integrated into traditional preventive services and PH perspectives influencing LA services

Workstream 3: the public health leadership role of local authorities

Embedding a public health perspective within and across directorates was promoted in some sites through: greater influence of public health teams within directorates; Elected Member engagement; breadth of HWB membership and debate; cross-directorate ownership of Joint Strategic Needs Assessments; routine use of health and health inequalities impact assessment; and, where relevant, improved co-ordination across districts and county councils. Credibility with Elected Members was key if public health teams were to exert influence across the local authority: clarity of communication; greater alignment with interests of local communities; local relevance; and context-sensitive implementation were emphasised. Public health was more likely to be prioritised across the local authority where a wide range of Elected Members was involved. However, views over what public health entailed in practice varied among both officers and Elected Members. The breadth of the Public Health Outcomes Framework (and dispersal of the public health budget and public health staff) meant a wide range of Scrutiny (or Select) Committees could potentially be involved, but not all were proactive in improving public health outcomes.

Public health staff were increasingly integrated into, and dispersed across, directorates. The trajectory, future role and sustainability of the public health profession were questioned. While involvement of public health staff in 'People' directorates was common, there was less evidence of involvement in other directorates. Second phase fieldwork showed that cross-directorate working had increased, although often on an ad hoc rather than systematic basis. Benefits of developing a broader public health workforce were highlighted and it was argued that public health training should take account of the new context.

The public health leadership role of local authorities		
Positive impacts	**Impacts less than anticipated**	**Shifts in perspective/future directions**
Elected Member knowledge and support for PH agenda increased during the study (although not a single portfolio for PH in most sites); PH teams were connected to wards/ local communities through Elected Members Acceleration /innovation in cross-directorate working and system-wide approaches; examples of PH service	Transition led to culture shock for PH teams; changes in organisational and accountability arrangements can be associated with reduced status/ autonomy; uncertainty over future role and sustainability of PH profession and professional development routes less clear Loss of experienced/specialist public health staff (healthcare public health,	Broader/social perspectives on what constitutes a public health problem; changes in governance for PH function Evidence-based PH leadership weakened in context of political decision-making; participative and consultative approach to evidence; more experimentation and learning at local level as to what works; less emphasis on population-based

delivery agreements across directorates and of requirements for PH impact of policies and of proportionate universalism being considered across all services; Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies become broader in some sites, with greater community involvement New responsibilities for PH teams (e.g. leisure services, preventive element of Care Act); potential of wider PH workforce across LA staff; new training possibilities Increased integration of services (children's services: (0-19); emotional health and wellbeing; healthy eating) PH teams providing health needs assessment and data analysis skills across directorates and helping targeting of services	health protection) with staff shortages, reduced capacity and recruitment difficulties. Less input into CCGs/primary care preventive services. Less focus on specialised route into the profession Cross-directorate working by public health teams was often ad hoc with more support needed PH services at District level in two-tier areas less developed/ coordinated and not always aligned with HWB priorities. Reforms better suited to single-tier authorities Integration agenda often dominates HWBs; HWBs described as confusing in a LA decision-making context with limited role in public health leadership Breadth of the Public Health Outcomes Framework is not reflected in scrutiny arrangements	approach Importance of political credibility, communication, influencing and networking skills if public health teams are to be effective Variation across sites over boundaries between state and individual responsibility PH teams moving towards strategic/influencing/advocacy roles and away from commissioning focus. 'Wellbeing' services often refer to prevention of hospital admission and early discharge PH teams increasingly involved in demand management, promotion of independence, and Sustainability and Transformation Plans Less central direction but more local control

Cross-cutting theme: health inequalities

Many sites had long-standing commitments to addressing health inequalities and impact on health or health inequalities was increasingly considered as part of decision-making processes across directorates. However, interviewees reflected a broader range of approaches to health inequalities than was evident in the NHS. Health inequalities were increasingly viewed in the context of wider inequalities. There was less emphasis on reducing premature mortality and the gap in life expectancy over the shorter-term but more emphasis on those likely to suffer from a range of inequalities over the longer-term, such as vulnerable children, those with poor quality of life and reduced life chances including migrants, socially isolated people, people with mental health problems, lone parent families, young offenders and children leaving care. The emphasis was on 'consultative' rather than 'analytic' approaches, involving consultation with stakeholders and the public. There was less emphasis on, and monitoring of, action by CCGs to reduce health inequalities.

Availability of national data at ward level would enable the impact of health checks on health inequalities to be assessed.

Cross-cutting theme: innovation

Local authorities were considered to encourage innovation which was further promoted by the co-location of public health teams. Examples highlighted in the study were brought together in an innovation framework. Co-location, combined with a programme for re-commissioning preventive services, encouraged increased community involvement and co-production, connections across preventive and other local authority services, with less emphasis on single interventions and greater recognition of the family and social context. Communities were seen as source of 'ground-up' innovation. Differences by site included: the extent to which innovation in public health was explicitly promoted by Elected Members and across all staff and levels of the organisation; the role of evidence and implementation 'at scale', as opposed to experimentation and local knowledge; communities as a source of innovation; the incorporation of local authority staff into a public health workforce; and the partnership role of the VCSE sector in developing innovative projects. Innovation in public health often derived from a combination of elements such as community engagement, co-design, action across a wider system and diversity of providers.

Results and relevance to policy

The transfer of public health responsibilities to local government was widely welcomed although potential benefits had been reduced by concurrent financial stringency. Impact within case study sites was also influenced by pre-existing commitments to a public health ethos, political leadership and history of partnership working. Key drivers of public health activity identified in the study include:

- Political leadership for public health and the extent to which this is reflected in decision-making across directorates;
- Views on factors influencing decision-making for public health investment, including: the balance between state intervention and individual responsibility; views of cost-effectiveness and social return on investment; concepts of prevention; and the nature of evidence;
- Alignment with local authority priorities, including children's services, managing demand for health and social care and promoting independence and self-care;
- The relative emphasis on data skills, commissioning responsibilities or wider influencing and advocacy roles of public health teams;
- Renewed emphasis on healthcare public health and secondary prevention, arising from the development of Sustainability and Transformation Plans (STPs).

Key questions for policy include:

- How are core public health activities to be defined in a new organisational and governance context?
- What is the critical mass and skill set required to fulfil the public health function in local authorities?
- What is the impact of local variation in relation to public health services, public health outcomes and health equity and how much variation is acceptable?
- How are minimum levels of provision for preventive services to be defined and consensus achieved over mandated services?
- What will be the impact of future funding arrangements on public health services?
- How can local authorities and public health teams maximise the opportunities STPs, Accountable Care Organisations and Accountable Care Systems may present for a place-based approach, combining greater reorientation towards prevention with early intervention across a wider system?

Conclusions and further research

Evaluating the impact of the reforms is made more complex by variation in the nature and context of individual local authorities, including commitment to a public health ethos and to partnerships prior to the reforms, concurrent policy changes and cuts to the ring-fenced and local authority budgets. The extent of variation across sites is not surprising but is indicative of the different ways in which prevention and public health are being defined, the public health contribution interpreted and the reforms implemented across local authority areas. In the four years since the reforms were enacted, roles and responsibilities of public health teams have been reframed, priorities re-aligned and services increasingly integrated. As preventive services have been re-commissioned (and sometimes de-commissioned), there are new opportunities for evaluating impact on outcomes for specific preventive services. Better data collection and reporting would enable more robust evaluation of the impact of spend on outcomes.

Dissemination plans

There have been five presentations of project findings to date and, in addition, a national conference was held in June 2017 to disseminate project findings. An article has been published in the Journal of Public Health (November 2017) and further academic articles and articles for publication in the practitioner press are in preparation.