

Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision

Views of national stakeholders

Research Report (1)

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Disclaimer

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Abbreviations

CCG: Clinical Commissioning Group

DsPH: Directors of Public Health

HIA: Health Impact Assessment

HWB: Health and Wellbeing Board

JSNA: Joint Strategic Needs Assessment

LGA: Local Government Association

NHS 5YFV: NHS Five Year Forward View

NIHR: National Institute for Health Research

PCT: Primary Care Trust

PHE: Public Health England

PHOF: Public Health Outcomes Framework

PRUComm: Policy Research Unit in Commissioning and the Healthcare System

SPOT: Spend and Outcome Tool

VCS: Voluntary and Community Sector

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1. Background to the study

Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision is a research project funded by the Department of Health Policy Research Programme. Its purpose is to evaluate the impact of public health reforms set in motion by the Health and Social Care Act 2012 and the project is being carried out by a research team from the Universities of Durham, York and Coventry and from Voluntary Organisations' Network North East (VONNE). The project began in January 2015 and will end in June 2017.

The reforms gave local authorities 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 public health grant, initially ring-fenced for two years (with the ring-fence subsequently extended until 2015-2016). The shift reflected the role of local authorities in influencing social determinants of health, their links with local populations and community networks and the benefits of local democratic accountability. As the reforms built on pre-existing local government involvement in public health and local partnerships, this study focuses on the impact of three new responsibilities that directly result from the reforms, reflected in three inter-related workstreams: (1) new budgetary responsibilities; (2) local authority responsibilities for commissioning preventive services through a range of providers; and (3) a leadership role for local authorities in promoting health and addressing health inequalities. Each workstream uses a mix of quantitative and qualitative methods and where possible, explores the impact of the reforms on health outcomes. Methods include surveys to provide a national overview, data analysis of spend and health outcomes and in-depth study of ten case study sites across England.

The first workstream investigates the deployment of the ring-fenced public health budget (2013-16), documents changes in the balance of commissioned public health interventions and compares changes to trends in relevant outcomes. Per capita expenditure will be plotted for each of the 18 categories of spend for the public health ring-fenced grant against a selection of relevant indicators from the Public Health Outcomes Framework (PHOF). Analyses will investigate the impact on health and health inequalities of changes in the balance of spend, innovative use of the public health budget and relevant initiatives across local authority directorates.

The second workstream explores changes in the provider landscape and innovation (including cross-sector approaches) in how services for promoting lifestyle change are being provided, remodelled and targeted to improve health and reduce health inequalities and how local communities are involved. It will assess the extent to which preventive services are integrated with other local authority services and with those provided through Clinical Commissioning Groups (CCGs). It will also investigate changes in uptake of selected services and collaborative approaches to preventive initiatives, including the 'added value' of pooled budgets. Local authorities have the potential to address some of the social conditions and contexts which make it difficult to change behaviour and can exploit different environments in which support for adopting healthier lifestyles may be offered. A key question is the extent to which new commissioning responsibilities lead to innovative approaches which may result in a greater impact on health and health inequalities than previously.

The success of the reforms also relies on health-related changes in mainstream local authority services: the third workstream explores the leadership role of local authorities in promoting health and addressing health inequalities and investigates public health initiatives which span local authority services.

Evaluating the impact of the reforms is made more complex by variation in local authorities and the range of partnership initiatives and innovative preventive services which predate the reforms. A previous National Institute for Health Research (NIHR)-funded study on commissioning for health and wellbeing in the former Primary Care Trusts (PCTs) (Marks, 2014) provides a basis for comparison as well as a governance framework for public health on which this study can build.

Research outputs are intended to contribute to effective public health commissioning for the public health budget and across local authority services. Building on theoretical approaches to governance for public health, the research will identify enablers and barriers in public health commissioning and contribute to the development of an innovation framework for preventive services.

1.1 Recent developments

In the two years since the reforms were implemented, there has been an upsurge of research, guidance and policy interest in the public health reforms reflected, for example, in: regular evidence updates from Public Health England (PHE) (see, for example, PHE and Institute of Health Equity, 2014); briefing and Resource Sheets on public health issues from the Local Government Association (LGA); and the Local Government Knowledge Navigator Evidence Review (South et al., 2014) which provided a public health evidence guide for local authorities. Two publications focusing on ‘transformation’ in local authority services (LGA and PHE, 2014; LGA, 2015) profile case studies which illustrate innovative approaches to public health being taken by local government. These include examples of ‘whole council’ approaches to public health; health impact assessment of local policies; integrated health and wellbeing services; involving other council directorates in delivering improved outcomes; and DsPH taking on wider roles in the council. At the same time, differences in culture and organisation are recognised, with greater weight being attached to the views of local citizens within local authorities. The public health budget has come under increasing scrutiny, including through Freedom of Information requests (Iacobucci, 2014) and most recently through the National Audit Office investigation into achieving value for money through the public health grant (National Audit Office, 2014) and the related investigation of the Public Accounts Committee (House of Commons Committee of Public Accounts, 2015). The recent development of a Spend and Outcomes Tool (SPOT) for local authorities (PHE, 2014) provides a tool through which the effectiveness of local public health spend can be assessed. Research into the delivery of NHS health checks and exploration of innovative approaches is being disseminated through a collaborative resource for the Health Check Programme (Available at: <http://www.healthcheck.nhs.uk/>).

The relocation of public health responsibilities to local authorities continues to be widely welcomed, given the social determinants of health and health equity (WHO, 2008; Marmot Review, 2010), the importance of promoting localism and place-based public health systems, building on community assets (Foot and Hopkins, 2010; Hopkins and Rippon, 2015), and the need to innovate in improving access to services

for underserved groups (NICE 2014). However, recent and ongoing research studies reflect many of the concerns initially raised in the enquiry into new public health responsibilities (House of Commons Communities and Local Government Committee, 2013), namely fragmentation and conflicting responsibilities, lack of power of Health and Wellbeing Boards (HWBs) and dangers of public health being squeezed out by the agenda for integrating health and social care. The impact of the reforms on the role and influence of the public health profession, and on public health leadership and the capacity of DsPH to influence investment continues to be debated (Association of Directors of Public Health, 2014; Royal Society for Public Health, 2014; Willmott, 2015).

In addition to these specific concerns, public health commissioning raises generic issues including: prioritisation and the use of evidence; factors influencing partnership and participatory approaches; and how to assess health impact across a complex public health system. There is ongoing research which explores related themes in the new public health system, for example, the Policy Research Unit in Commissioning and the Healthcare System (PRUComm) uses obesity as a tracer for exploring the new public health system across five case study sites (the Phoenix Project (DJH is a member of the Advisory Group)) and methods of decision-support for prioritising public health investment is the focus of one of the projects funded through the School for Public Health Research (2012-2016) (DJH is PI and LM is CI). Building on the reforms, PHE and the Manchester Academic Health Science Centre have developed 'Well North', working collaboratively with local authorities to develop and test innovative approaches to improving health outcomes in the most disadvantaged communities. A second study funded through the Health Reform Evaluation Programme (HREP), 'Evaluating the leadership role of Health and Wellbeing Boards', is also led by Durham University (DJH is PI and SV is CI) and links are anticipated with the other projects funded as part of the programme. Liaison across some of these studies is already facilitated by cross-membership of research teams and liaison with other studies is important in order to avoid duplication of case study sites or survey overload and to maximise synergy across the projects.

2. Scoping phase

The study adopts an iterative approach and analyses from each of four research reports, carried out as part of an initial, scoping phase (January to August 2015) will inform data collection in 10 case study sites across England, scheduled to begin in September 2015. This first research report concerns interviews with national stakeholders, which were designed to provide an overview of key issues and debates. The second report (May 2015) focuses on the public health budget, while the third (July 2015) concerns two national surveys, one of Voluntary and Community Sector (VCS) members and local Healthwatch members of HWBs and another of VCS organisations involved in delivering services or interventions to improve health and reduce health inequalities (whether members of HWBs or not). Analysis of a national survey of DsPH and of local authority and CCG commissioners is the subject of the fourth report (August 2015).

3. Views of national stakeholders

Interviews with national stakeholders were designed to identify key issues to be addressed in the ten case study sites, inform research instruments, explore criteria for the selection of sites, and recommend dissemination strategies. They were also intended to inform the development of the first of two national surveys of commissioners (Report 4).

The interview schedule (Appendix one) began with questions exploring views over the public health reforms and then reflected research themes related to each of the three workstreams outlined in the proposal, that is: commissioning preventive services; the leadership role of local authorities; and the deployment of the public health budget. It also included questions on the PHOF, mandated and non-mandated public health services and public health budget reporting. In recognition of the fact that two years have elapsed since the reforms were implemented - and since the proposal was developed - questions also reflected recent debates over the public health commissioning system.

3.1 Methods

Organisations (n=8) with a national perspective on aspects of the public health reforms were selected by the research team and an individual holding a relevant senior role was contacted. In addition, two academics with a national perspective on issues related to the study were invited for interview. The organisations included the Faculty of Public Health; the Association of Directors of Public Health; Healthwatch England; the Local Government Association (two interviews); the Centre for Public Scrutiny; NHS Clinical Commissioners; Voluntary Sector Organisation. (We invited representatives of Public Health England to participate but all declined due to work commitments.) Four interviewees also had a local role (for example, as members of HWBs) and one interviewee was leader of a council. The draft interview schedule was piloted with a former DPH, and with consent, this interview transcript was also included in the analysis, making a total of 11 interviews. Semi-structured interviews were carried out by Dr Sally Brown between February and March 2015, either face to face (n=3) or over the phone (n=8) with each interview lasting for about an hour. Consent was gained beforehand and comments are non-attributable. All interviews were recorded and transcribed by a professional agency and a thematic analysis was carried out by two members of the project team (LM and SV). In order to preserve anonymity, the background of interviewees is indicated, but not their role or organisation.

The interviews were intended to explore a range of views: given their different backgrounds, not all topics were commented on by all interviewees. As the number of interviews is small, findings are indicative rather than representative of the national picture. As national stakeholders, there was relatively little discussion of specific services or examples of innovation.

The following section reports findings, followed by a discussion which also identifies issues to be addressed in the case study phase of the study.

3.2 Results

Results are divided into the following main sections: views of the public health reforms; whether views had changed over the previous two years; commissioning in local authorities; auditing performance; innovation in preventive services; the leadership role of local authorities; and views of the public health budget and of the health premium.

3.2.1 Views of the public health reforms

The transfer of public health responsibilities from the NHS to local authorities was described as a significant change, involving the relocation of 3,500 public health staff and of £2.79 billion (2014-15)¹ through the ring-fenced public health budget. Most interviewees were in favour of this transfer: it was described as ‘universally welcomed by elected members and local authority chief executives’ and from a public health perspective, was seen as aligning the agendas of local government and public health.

Reasons for support

Reasons for support for the reforms fell into a number of categories. First and foremost, the reforms underlined a social model of health, interpreted by some interviewees as a formal recognition of the role of social factors in health and health inequalities and reflecting a shift in emphasis from a clinical model and from the emphasis of the NHS on lifestyle change. The reforms served to reaffirm the remit and the leadership role of local authorities in influencing social determinants of health through their influence on housing, education, environment, transport and town planning, although clearly much also depended on the policies of central government. Moreover, the transfer served to align the public health function with local authorities’ responsibilities ‘as guardians of their places and guardians of their people’. Levers for change were located in the local authority and some interviewees emphasised that public health had been a ‘Cinderella service’ in the NHS. One interviewee commented:

I think 80% of [local authorities’] responsibilities sit within the social determinants of health, don’t they, around issues of transport, housing, urban planning, environmental health. Most of the issues sit there, in mainstream public health, whereas public health within the NHS, it seems to be focused almost exclusively on the issues of smoking, alcohol and obesity. (Policy adviser A)

The corollary of this corporate responsibility for public health was that local authorities could reflect their public health responsibilities in all local authority budgets and through the range of legal powers available to them, that is ‘the totality of the budgets and the legislative resource’. Examples were cited of councils working with districts to make an impact on public health through a system of matched funding; starting to embed public health across all council departments; and setting up a ‘determinants of health’ fund from the public health budget for which directorates could apply and then match funding to meet shared public health objectives. Local authorities could also develop integrated and multi-agency approaches to single issues

¹ www.parliament.uk/briefing-papers/SN06844.pdf, page 11

such as tobacco control, to include housing policies and working with local communities. This comprehensive approach needed to be reflected in joint strategic needs assessments (JSNAs), and in partnership arrangements including with local employers and education providers. Through local authorities articulating their public health responsibilities, public health could become more visible and a 'silo' approach to public health could potentially be avoided:

What I'd like to say is that it's changed some of the discussions, so that actually there's scope for local authorities to think, to frame part of their responsibilities in health and wellbeing terms rather than simply thinking about housing or transport or social care. (Policy Adviser B)

Second was closeness to local communities, including through elected members. Councils had the capacity to provide preventive services in council locations, such as libraries, and to make links with services associated with underlying determinants of health, such as housing. They could draw on their network of services to identify underserved groups, raise awareness of preventive services and improve access to preventive services:

*I think one of the benefits of the transfer has been the network of community groups that local authorities use on a day to day basis, whether it's faith groups, whether it's volunteer groups, whether it's the number of voluntary organisations who local authorities commission services from, there's a massive network of services. Even things like the housing teams in local authorities, they come across people on a daily basis, those people with the greatest health inequalities, whether it's the benefits team, whether it's the social care team, whether it's the meals on wheels people.
(Local government representative)*

This formed part of the neighbourhood focus of local government and could be reflected in community capacity-building, with identifying local problems and enabling local solutions. Community health and community development could be considered together. Developing 'systematic feedback' from communities was considered a prerequisite for commissioning effective preventive services. A cross-directorate approach could be adopted for neighbourhood management and volunteering and co-production further developed (including with the voluntary sector) as a way of engaging communities.

However, in this context, it was emphasised that engagement with diverse communities, especially the most marginalised communities, needed a proactive approach by local authorities, rather than their relying solely on processes of democratic accountability. Several interviewees highlighted the 'potential' of local authorities to engage successfully with these groups (in contrast with NHS-based public health), but little evidence was provided to suggest that this was being achieved in practice.

Third was the role of HWBs, considered by most interviewees as a 'good idea', promoting collaboration through 'the right kind of architecture' and having a route through the JSNA, as well as their membership for identifying local health issues and influencing preventive services. HWBs were varied and this included the extent to

which they played a commissioning role. However, some interviewees argued that since the reforms, it had become easier for CCGs and local authorities to collaborate:

Here we are, two years into formalised health and wellbeing boards, talking and meeting regularly, agenda planning, working out, aligning, commissioning, etc. We didn't talk four years ago. (Elected member)

Evidence of collaboration could be seen in pooled budgets, although no examples of pooling arrangements were offered.

Fourth it was argued that the reforms had made it easier to change providers for preventive services, with delivery of health checks offered as an example. The VCS could be commissioned to play a greater role in engaging with disadvantaged groups, although it was important to identify organisations already in place and develop a strategic, asset-based approach to engagement, building on collective community resources:

I would always start with what organisations are already working in this area, and talk to them about what's been done before and what hasn't. And I think for some of the small minorities there might not be organisations working with that particular group, so again it would be going back to national and regional strategic partners around how do we access this group, so very strategic engagement. (VCS representative)

Fifth was expertise in public health teams in relation to the evidence base which could be used to inform strategies:

What public health can bring to local authorities is a systematic approach to needs assessment and data. (Elected member)

A number of interviewees commented on the benefits of the transfer to the public health function through the role of local authority Overview and Scrutiny Committees and of local councillors in ensuring local needs were being addressed. Local authorities also provided legal support and expertise in procurement (further discussed in section 3.2.3).

Areas of concern

Along with the reasons for support outlined above, a number of concerns were raised over the reforms and their impact on promoting health and on commissioning. A key concern was the confluence of the transfer of public health responsibilities to local authorities with the implementation of austerity measures, which had led to a period of retrenchment rather than of expansion. This had a number of potential effects: there was more likelihood of drawing on, or 'reframing' the ring-fenced public health budget to support existing public health-related activity across directorates; and there was less likelihood of councils infusing public health activity into the activities of directorates which could support public health, such as housing and planning, given a diminution of resources (financial and human). It was argued that there was an important difference between specifying how public health money was used to support public health-related activity in other directorates and making the decision to target budgets from other directorates towards a clear health objective. It was also

argued that a ‘culture of austerity’, not just a lack of resources, made risk-taking - including ‘spending to save’ - less likely. However, one interviewee argued that ‘generally councils have put more into public health than was originally transferred with them’.

A second area of debate was the impact of the transfer on the public health profession and on their influence over commissioning specific preventive services or on relevant areas across local authority directorates. The transfer amounted to ‘significant churn within the public health community’, resulting in different accountabilities, terms and conditions; problems of parity with local authority staff and different degrees of influence; and disrupted relationships and partnerships within and across sectors. One interviewee argued that the ‘specialist role of public health is less prominent’ and another that public health consultants, especially those who were medically trained or who were interested in more technical aspects of public health, would ‘be split off from their peers’, or not be recognised as consultants. Public health teams were described as ‘shackled’ by the fact that they could no longer routinely access GP data.

Different views were expressed over the influence exerted by DsPH. Some interviewees expressed concern about a loss of independence in the new role of DsPH as paid officials of a local authority acting in a political context, and that some public health teams were struggling to influence ‘the chief exec, the leader or their colleagues in other departments’. Furthermore, the independent annual public health report could become a corporate publication.

It was also noted that the corporate agenda was of prime importance for a local authority:

If they [DsPH] want to be fully part of the authority, then they have to support the corporate agenda. We don't offer independence, as I've heard some directors of public health describe it, to directors of adult services or directors of children's services. So the question for a leader would be why are we giving the DPH this independent role when we're not giving other officers that level of independence? (Local government representative)

However, it was also argued that influence of public health teams in the NHS and on chief executives had also been limited. In the NHS, DsPH might have had less ability to comment on variants to national NHS policy, but, as one interviewee noted, after the transfer ‘there may be less ability to talk about some local issues because of local sensitivities, but if the director of public health is in tune with the local politics there might be more ability to talk about issues nationally’.

In local authorities, DsPH were able to draw on evidence and express independent views to elected members on the same basis as other local authority directors:

What they need to do is enable elected members to understand their professionalism, to respect their professional independence, and to provide advice which is helpful to politicians in making the right decisions. (Policy adviser A)

Having to speak out and take an independent view could be seen an indication of relationships having broken down and an inability to influence decisions at an earlier stage in the decision-making process.

One interviewee argued that despite a proposition in the initial White Paper that DsPH were to be jointly accountable to PHE and to local authority chief executives, accountability to the latter meant that their role in relation to the former was unclear. While one interviewee considered that public health was more visible in local government than in the NHS, another argued that, over time, public health input had become increasingly valued within the NHS. While public health was sometimes described as returning 'home', both the public health profession and local authorities had changed:

There's still a degree of uncertainty about where it lies, what the authority is. It's not quite the same as adult or children's services, or not quite the same as public health was before 1974 when it was a clear duty and public health was there clearly as a major role with the medical officer of health being a key person in the authority. (Public health representative B)

Their position in the local authority - as chief officers or as second tier officers, often accountable to the directors of social services - was considered crucial to the extent to which DsPH could exert influence:

...you've got to be a chief officer, you've got to be sitting around in the management team meetings, and you've got to be sitting around in the cabinet discussions and building the kind of relationships which allow you to provide strategic direction for political decisions made within the cabinet and made within the council. (Policy adviser A)

As the reforms had taken root, councils had adopted different approaches to incorporating public health functions, as reflected in the different locations, accountability arrangements and seniority of public health teams, whose influence varied across authorities. However, it was noted that public health had always been vulnerable to being 'peripheralised', and that despite the emphasis on prevention in the NHS 5 Year Forward View (5YFV), resources were not being directed in this direction. It was important to build on the totality of local resources when thinking about prevention.

And I suppose I'm very much into the idea of asset-based local health, and using all the local resources people, professionals and talents to create public health. And by putting them in local authorities I feel health services have not seen it as their role (CCG representative)

Despite overall support for HWBs, a third area of concern was related to their effectiveness in the context of a commissioning system which some interviewees regarded as having increased in complexity with the creation of CCGs. There were risks of HWBs focusing mainly on the agenda for social care and service integration. Despite being statutory boards, one interviewee considered that they did not 'sit neatly' into a local authority structure, and this was particularly the case for the wider health and wellbeing agenda, which needed to be considered within and across

directorates. One interviewee commented that as well as local partners, the HWB needed to reflect ‘the breadth of local authority responsibilities in some way, either by place directors as well as people directors, or through the leader chairing, or in some other way that you got it right to the top of the local authority’.

One interviewee considered that HWBs could be viewed as ‘owned’ by the local authority, with the CCG member as the ‘invitee’. In the same way, not all CCGs recognised the significance of HWBs, reflected in a lack of senior CCG representation. In contrast, having CCG members as co-chairs of HWBs was suggested as one way of underlining the importance of local authority and CCG collaboration.

Accountability mechanisms were considered unclear: CCGs did not need to act on HWB agreements or provide an account of their commissioning decisions. Moreover, they differed in the extent of collaboration, as reflected in the use of pooled budgets. One interviewee commented:

There are some CCGs which will see this in terms of public value and say we have common cause and we can pool our resources to a greater end, which is about health and wellbeing. And there are others which will just see it as an opportunity to either shift the responsibility for a particular kind of commissioning, or shift the responsibilities for a particular kind of service provision. (Policy adviser C)

It was questioned whether HWBs would constitute an adequate mechanism for furthering the agenda of moving resources upstream along care pathways, which, it was argued, had been a potential benefit of public health being located in the NHS, where it was possible to make the economic case that preventive initiatives provided a return on investment for the NHS.

A further caveat was the reach and engagement of HWBs at a local level. HWBs did not address failures in coordination between general practice and the local authority locally and it was argued by one interviewee that local coordination - or a local health leader/facilitator - was required to make these links, expressed as follows:

I think there’s an awful lot that we could be doing between general practice, schools, housing authorities, local authority services etc., which isn’t being done really. And we sometimes think we’ve fixed it simply by co-commissioning at a higher level or having health and wellbeing boards planning the general map of things. And I don’t think any of that’s going to be as effective as if we connect it properly to what your local population of clinicians and people feel would be helpful and necessary. (CCG representative)

Although local Healthwatch, as a statutory member of the HWB, provided a formal channel for representation of local voluntary organisations and the ‘public voice’, CCGs did not carry out their legal duty to engage with patients and the public through Healthwatch, which one interviewee criticised as reflecting ‘disarticulated systems for engaging with the public at a local level’.

Finally, the extent to which there was a cross-directorate approach to public health was unclear. For example, health impact assessment (HIA) was potentially a key route for infusing health considerations into every area of policy ('It could be a very important weapon in the armoury') but there was little evidence of its use to date or of HIA being included in reports. One interviewee noted:

Well ideally it would be the entire budget, not just the ring fenced. You would apply a health impact assessment to all budgetary commitments. So it's getting the thinking into the system, and health impact assessment is a way of doing that. (Public health representative A)

It was argued that an HIA approach, which involved different kinds of evidence, could counterbalance largely epidemiological approaches adopted by many JSNAs.

Links with other directorates were limited for many HWB members, as one interviewee commented:

But I've never been in the same room with someone who's heading transport. They tell us, they give us reassurances that the transport links are very good but how do we know? So there doesn't seem to be one streamlined model incorporating all that. (Healthwatch representative)

Some problems raised were common to reorganisations in general, including changes in partnerships, networks and working relationships. With this came a danger of not recognising what had gone before or of failing to build on existing assets and more difficulty in signposting to services as organisations changed.

3.2.2 Reforms two years on

Interviewees were asked whether and how their views had changed in the two years since implementation of the reforms, in 2013. Most were still positive, although problems of fragmentation and coordination, including for commissioning preventive services, had become more evident over time. Collaboration was required across local authorities and CCGs across areas such as mental health and obesity and it was argued that the 5YFV required greater collaboration. Despite its emphasis on prevention, it was argued that there was 'a whole series of mechanisms which prevent prevention becoming a priority'. Despite the requirement for local authorities to make arrangements for public health advice for CCGs it was argued that such services were not uniformly being provided and that there was 'no real pressure on local authorities to provide the healthcare offer from public health to the CCGs'. Although most interviewees were not aware of any problems related to changes in arrangements for health protection following the reforms, one interviewee considered that there was a lack of local knowledge and that it was 'more difficult to resolve problems of supply of either people or particular sorts of equipment that would need permissions up and down the system'. It was noted that while councils had few statutory requirements in this area, there was some lack of clarity over the role of the DPH and having the correct contracts in place for local staff who might be called on to carry out health protection related tasks.

The reforms had also meant a decline in the resources previously available at a regional level.

There was criticism of an increased narrowing of focus in HWBs, their lack of statutory powers and JSNAs as ‘retreads of previous ones’, mainly reflecting epidemiological evidence and health service utilisation rather than reflecting engagement with the public. There was some concern, too, over the extent to which councils saw themselves as leading on public health, which required a change in culture:

So thinking about themselves as leading on public health or health and wellbeing for their locality is a really big ask, and I’m not sure that many have really understood that..... But they have to want to lead it, and they have to feel they should be leading it. And I think those two elements are things that can’t be framed in terms of legislation of policy; they’re actually about a change in the culture’. (Policy adviser C)

The effects of the public health reforms were described as less evident to clinicians on the ground, both in relation to uptake of preventive services and to changes in services offered:

So there’s a sort of rigidity still which I think could only ever be overcome by a greater meeting of agendas between my patients, my practice, local estates, local authority and the rest of it. And those sort of meetings aren’t happening yet. (CCG representative)

There was a need for greater ‘working in tandem’ and ‘mutual learning’ across general practice and local councillors, in addition to more local ownership and localism in commissioning, with public health being central to local practices and communities. The same interviewee commented:

I suppose I’d like to see delegated resources to communitieswhere communities can actually develop their own assets, whether we’re talking about time banks or volunteers or involvement with the voluntary sector or some very local specific contracts ... And so until we get a much closer feel locally about what public health commissioning is actually doing for us, or what it involves and what our role is in it, I think it will continue to be slightly ethereal.

This was reflected in the view of an elected member, who emphasised the importance of devolved budgets and increased localism:

Actually what we do do is let go, we deal with things at a far more strategic level here at the county, or whatever a unitary would look like, deals with high level strategic stuff, but actually lets go of the local delivery stuff to more community based groups like town and parish councils, with their local councillor and parish councillors, as leaders within their communities, and give them that responsibility.

Echoing this view, another interviewee argued local forums could bring together public health data with views of local leaders, clinicians and local people in ‘local conversations’ to inform commissioning plans and develop initiatives, thereby making

public health more intrinsic to local communities - a 'communal venture' and also likely to improve the effectiveness of initiatives.

3.2.3 Commissioning in a local authority context

Interviewees commented on a number of differences between commissioning in the NHS and local authorities in terms of: the commissioning cycle and the relative emphases accorded to phases in the commissioning cycle; an emphasis on evidence from local communities; and new influences on public health commissioning. Some challenges were also raised.

Commissioning and procurement

While one interviewee described a commissioning cycle for public health services which had been adopted by the council, others commented that local authorities had more experience and expertise than the NHS in the contractual elements of commissioning (procurement) rather than broader strategic needs assessment or in needs assessment as the first phase of a commissioning cycle. Unlike in the NHS, commissioning in relation to local needs assessment could now be tested through scrutiny committees. Local authorities also had access to extensive legal resources, 'nailing down' commissioning decisions and thereby avoiding legal challenges from providers, which were described as more frequent in the NHS. The combination of tighter contractual procedures, new tenders and cross-directorate collaboration could lead to better specification of public health-related changes, including across directorates.

It was argued that NHS contracts had often been 'rolled over with little scrutiny' and that local authorities brought increased efficiency, scrutiny and transparency in the contractual elements of commissioning, along with differing priorities for investment and a less compartmentalised approach:

They will invest in new areas, they will also disinvest from those that they see as not achieving the necessary outcomes that is required of those services. And we're also seeing a shift as local authorities change their priorities from those that were previous NHS priorities. (Local government representative)

Councils were described as moving away from in-house provision and were both 'informing the market what is needed' and providing information relevant for accessing providers through a range of media, especially electronic media. Councils could commission services such as health checks from a wide range of providers, including the VCS, using a range of locations such as temples and mosques to increase accessibility. Interviewees cited examples of recent renegotiation of such contracts on a large scale, including the involvement of pharmacies and leisure centres, although not all interviewees agreed that diversity of providers was inevitably more innovative or more efficient. It was argued that while there could be benefits in re-tendering services on a regular basis, constant and obligatory re-tendering could lead to fragmentation:

...your school nursing might be won by tender from one organisation, and the health visiting might be won by somebody else. So you've got that separation and disintegration from the start. (Public health representative A)

While there was support for the involvement of the VCS, and the reforms were seen as providing opportunities as contracts came up for renewal, especially in community engagement, some interviewees argued that the supply side required development:

I think the danger is when we're together as an integrated board we sort of say oh yeah the third sector will be able to pick that up, and we just make those statements. But actually they're often a million miles away from having the skills and the capability of doing it. (Healthwatch representative)

It was also argued that the VCS had become more professionalised and less flexible.

There had been few statutory requirements for commissioning public health services in the NHS: they were described by one interviewee as 'ad hoc', with public health commissioning taking place 'at the margins'. The new arrangements meant that the categories included in the public health budget could be seen as a coherent programme of work.

Intelligence from local communities

Interviewees emphasised the importance of engaging with, and gathering evidence from, local communities if behaviour change strategies were to be effective. Councils could build on community assets, recognising the role of the VCS not just as providers but as a route for connecting with community networks:

Communities have got tremendous capacity within them to solve problems themselves, and so I think not only being very clear about the needs of different parts of the community, but also the assets within those communities that can help those communities to help themselves if you like. I think that's a real opportunity for councils. (Policy adviser B)

Community engagement in developing the JSNA and in joint production of preventive services implied a different approach to public health commissioning. The development of 'integrated wellness services', for example, was a response to the fact that individuals experienced overlapping vulnerabilities and that such a service could also provide a gateway to the range of local authority services, including housing and leisure services, as well as more specialised lifestyle management services. More broadly, some interviewees saw the potential of community budgeting and developing pooled budgets across a range of agencies for developing innovative ways of commissioning, based on a social intervention model.

There was a perception that public health commissioning came down from 'on high', rather than 'something that's grown from the average housing estate upwards'. While local authorities were more likely to involve local communities it was also argued that more could also be done to support the VCS in developing an evidence base for their services and for the JSNA:

We've seen a real thirst amongst the voluntary and community sector, you know, ... looking at their own evidence and ...their own data about how they turn that into useable intelligence either for JSNAs or for their own business case or for tender opportunities. (VCS representative)

Influences on public health decision-making

Interviewees discussed the influence of the public health team, elected members and HWBs. It was argued that councils were 'less amenable to senior specialist roles than the NHS', and instead were more familiar with a combination of 'senior generalist roles and more junior specialist roles'. In addition, in local authorities, formal decision-making rested with members and unlike in the former NHS PCTs, DsPH did not have a formal decision-making role. Ironically, despite a centralised NHS, there had been some room for local manoeuvre for public health-related initiatives in areas where there was no central guidance, while in local authorities key priorities were determined 'a little closer to the local environment' with perhaps less freedom and flexibility for public health teams.

The key role of elected members in influencing budgets was cited by many interviewees. In some councils (such as hung councils), there could be a very short time for councillors to make an impact, which could act as a constraint on the longer-term strategies needed to improve public health. In some councils too, elected members could be less interested in public health issues:

You can have all the money in the world but if members don't want to do anything you're in trouble. (Public health representative A)

Potential tensions between members and DsPH were recognised by interviewees and one interviewee argued that there should be 'greater parity' across a health and wellbeing system, combining the mandates of elected members with professional advice.

HWBs were viewed as the main influence on the kinds of preventive services to be commissioned, providing strategic cohesion and binding together 'all the individual activities that particular agencies and particular projects are doing'. Local Healthwatch, as a statutory member of the board, could focus 'local intelligence' and identify gaps in service. It was important that specific services, such as health checks were 'built into a comprehensive strategy' to tackle public health issues'.

HWBs and local authorities were described as having a 'wider perception' of the action required to make a difference to health and wellbeing. They had a broad view of partnerships and there were examples of local authorities taking a strategic approach through developing partnership and collaborative arrangements to address social determinants of health, despite austerity. For example, councils could make changes in leisure, transport, libraries and housing - and were also large employers in their own right and could, therefore, act as an example.

This broader approach could also encourage greater involvement of the VCS, which, in turn, was described as having a more holistic approach and a wider view of what counted as prevention. It was argued that councils should take a 'more inclusive' view of the VCS although it was also recognised that responsibility for commissioning from the VCS - whether from CCGs, the local authority or specialised commissioning - was sometimes unclear:

I think, again I think it's a mixed bag, that some local authorities have stayed with very traditional ways of tendering for services. Other health and

wellbeing boards and local authorities have begun to think through well if we're going to commission through our community and voluntary sector, how could we make it easier for them to make bids and how can we therefore adjust the tendering process to take into account the social good? (Policy adviser A)

However, a further influence on HWB priorities was the importance of managing demands on health and social care and fostering independence. An emphasis on social care was evident in one interviewee's response to a question over the social determinants of health, which focused on the broader context of social care as '*social care determinants and inequalities and prevention never sit just with social care*'. This emphasis was reflected in joint commissioning boards for adults and children spanning public health, health and social care. Planning for health could also be interpreted as cross-directorate planning for housing and transport which was seen as suitable for a growing population of older people:

So when we're considering local plans at the moment, we need to consider where housing development is, what access they have to transport, whether they're on the side of a hill and whether they've got bus stops with benches, whether they've got access to walks and parks and things like that, to keep people fitter and healthier for longer. (Elected member)

Commissioning for health and wellbeing could therefore conjure up a range of possible interventions within a local authority context.

Challenges for public health commissioning

Interviewees raised a number of challenges for public health commissioning, some of which such as austerity, the role of the public health team, budget restraints and fragmentation have already been discussed. Other issues raised included 'rigid spending rules' and lack of devolution; short-term financial settlements; the cultural shift and political will required to make public health commissioning work; the importance of recognising public health as a 'front line service' within local authorities; accessing evidence and being able to measure outcomes. The breadth of public health activities was a further challenge raising questions of which preventive activities were to be prioritised:

There is a range of things on the public health long list that local authorities are still trying to struggle with in terms of priorities. I think that is one of the biggest challenges. (Local government representative)

The same interviewee commented that a main question for commissioners was value for money:

But the number one question that is often being asked by commissioners is where is the return, who benefits, and anything that external bodies can help local authorities understand the evidence more, and also the return on investment would be greatly welcomed.

In relation to the evidence base, while PHE was cited as a main source of support, commissioning support services, although designed for CCGs, were also relevant for

services that spanned CCGs and local authorities, such as children's services. Some interviewees considered PHE to be under-resourced but others highlighted PHE support related to standards, community capacity-building, and the evidence base. However, it was also described as having a 'different viewpoint and not familiar enough with the local government environment'. Another interviewee considered it needed to be more radical in its advice to government and a further considered that its work programme on the identification of local priorities needed further development through engaging with the public.

3.2.4 Assessing the ring-fenced public health budget

Reporting public health spend against 18 categories was considered an advance on the opacity of public health spending in the NHS. The current budget allocation reflected NHS priorities, with budgets for drug and alcohol treatment services and for sexual health services accounting for over half the budget. Some interviewees were critical of an allocation formula influenced by deprivation and life expectancy when most of the budget was spent on younger people's services. Given the new allocation formula for 0-5s (from October 2015), the lack of a similar approach for services for 5-19s showed a lack of consistency. One interviewee noted:

But in reality the services that we're tending to commission are for young people. And so you might have a high mortality rate, which is a general measure of deprivation, but you're applying the money to school nursing or drug services or teenage pregnancy. And whilst broadly those problems mirror deprivation as well, there's a disconnect really about if your money was boosted or reduced would you need any less young people's services?
(Public health representative A)

While initial deployment of the budget had been influenced by historical spend and requirements of mandatory services, in future, the main influence was likely to be the 'political strategy of the council' and the views of elected members, rather than the centrally determined priorities of the NHS. It was argued that demands on public health funds were not new, although post-2013, the demands were not from acute care services but from trying to balance the books in local authorities.

Others highlighted the importance of addressing major public health challenges and of spending the budget on what could make the greatest difference locally, reporting to the HWB on how it had been deployed. Identifying whether spending was having the expected outcomes was described as going 'to the heart of the scrutiny and accountability agenda'. Nevertheless, return on investment could prove difficult to demonstrate over the shorter-term.

Many interviewees pointed out that the debate needed to move away from a focus on the public health budget - 'the 4%' - which should not be viewed in isolation from the rest of local authority spend. It was argued that 'this debate tends not to occur in the most innovative local authorities'. Instead it was argued that the public health budget should be used as a catalyst or as 'seed money' to shift the major spend of local authorities and that the entirety of the local authority budget should be maximised for public health benefit across the services local authorities provided.

Linked to this was the fact that ring-fenced budgets were not supported by the local authority sector as local authorities had to work across the whole system. There were only two ring-fenced grants - the public health grant and the schools grant - and a ring-fenced public health budget did not protect other parts of the local authority that were under pressure.

There were different views over the distinction between mandated and non-mandated public health services. Some interviewees did not consider it a helpful division, given some variation in how authorities met mandatory requirements. Others felt that local relevance was also important:

And I think that historicallywhere there was an impetus to follow, to spend money in certain ways, to follow certain national programmes undoubtedly helped some areas but just was not relevant in other areas. So yes, there are some areas of activity where we probably need to make sure that everybody is taking action, but we need to just make sure that those areas where we're spending that money is relevant to each local place. (Policy adviser B)

However, one interviewee considered the distinction protected essential services that were not high profile or might not be viewed as 'vote winners', as well as those areas where the evidence base had been contested, such as health checks. There was a degree of irony in the fact that follow up services were not mandatory, as one interviewee commented:

But there are some oddities like we have to weigh and measure children, but we don't have to do anything about it. So that's a bit odd, but I think we've recognised we need to do something about it. (Public health representative B)

The accountability and reporting arrangements for public health budget reporting needed clarification and it was argued that the public health budget should be thoroughly reported across a range of partners. One interviewee suggested the following reporting mechanisms:

So it has to report to the health and wellbeing board. So that's at a local level. It should be reported through the councillors, through the local residents. It should be reported upwards to Public Health England. It should be reported to NHS England, because it engages with them. It should also be reported I would have thought to local GPs through the CCGs. Yeah, so everyone should know about it, and they should see ways that they can potentially articulate their own work in relation to what's being commissioned for public health. (Policy adviser C)

3.2.5 Auditing performance

It was noted that performance of a locally-led public health system was a matter for local authorities, not a national inspectorate. Assessment of public health performance would, therefore, follow the same procedures as for other council services, including scrutiny committees and, in the case of health and social services, local Healthwatch. As part of this, local authorities could draw on 'sector-led improvements' and 'peer review'. Other interviewees emphasised the role of the HWB and how JSNAs could be used to incorporate measures of change over time.

Some interviewees considered national frameworks for assessment, such as the PHOF, as important although it needed interpretation within a local context. The PHOF was not considered to have exerted much influence to date (or there was no comment made about its use). Some scepticism was expressed given that frameworks ‘came and went’, outcomes were long-term and many areas relevant to public health could not be easily measured or put on score cards: outcome measures were also prey to gaming strategies. Bespoke surveys were often needed for aspects of the mental health agenda, such as community wellbeing and trust, for example. The community needed to be involved in assessing outcomes, or as one interviewee put it, ‘public health ought to be judged by the public’.

One interviewee highlighted the relevance of the Marmot indicators for judging the progress of local authorities and others considered that a combination of indicators was required:

So I think it will be a combination of further developments of the public health outcomes framework, locally sensitive specific indicators in areas of concern, in the context of a local performance framework that is easily understood by members. (Public health representative B)

As mentioned above, interviewees emphasised the importance of using the public health budget to catalyse development. However, it would be difficult to demonstrate causality as effects could be complex and interactive and distributed across a whole system.

3.2.6 Innovation arising from the reforms

Local authorities were described as a good source of innovation given their local flexibility. The view was expressed that too much central oversight and monitoring could stymie local innovation in what was intended to be a locally-led public health system. As described in section 3.2.1 above, the potential for innovative approaches underlay many of the reasons for supporting the reforms. In some authorities, a public health ethos had predated the transfer of formal responsibilities, although the situation varied from one local authority to another. However, the reforms added ‘legitimacy, impetus and visibility’. Prerequisites for public health innovation depended on partnerships - especially ‘tight’ partnerships - and engagement between public health teams and elected members, although some public health staff were described as ‘traditionalist’ in their approach.

Interviewees considered innovation was required in order to reduce demands on services, including social care services, and to address health inequalities. The latter required innovative approaches to engaging local communities so that they saw prevention as important. It was argued that ‘the fully engaged community, was a prerequisite not only for a sustainable NHS, but also for addressing the social determinants of health and health inequalities’. Improving access to services was possible through better location of services, through community budgeting approaches, co-planning with communities and co-design.

However, there was more emphasis on the potential for innovation than on examples of innovative practice.

Interviewees highlighted a number of reasons why it was difficult to attribute changes to the reforms or to draw conclusions over their impact. First of all, the reforms were recent and changes were difficult to pin down. Delays in getting data, including data on uptake of preventive services by those most in need of them, was also a factor. While it was recognised that delivery of health checks and child measurement had gone up, this could be attributed to the fact that these services had become mandatory.

Second, in some cases, innovation built on the work of authorities who were already active in public health, with a tradition of ‘civic socialism’, and many DsPH had been joint appointments across PCTs and local authorities. Innovative practice which followed the reforms was not necessarily due to them and there were many examples of innovation and joint working in areas such as child obesity, while drug and alcohol services had been jointly commissioned prior to the reforms. Some interviewees argued that innovation in local authorities was not a solely a function of the transfer of public health staff:

I mean arguably you could say the reform of moving public health in, that's a single thing, but actually transformation has happened by local government, because they have of necessity needed to do this. Because they know that the demand is increasing, they know their finances are reducing, they have to do things differently. (Elected member)

Third, major initiatives, such as the Marmot Review, *Fair Society, Healthy Lives* (2010) had already made an impact on local authorities with a majority adopting the six Marmot principles. Initiatives, such as the Fairness Commissions, had also exerted an effect. Many authorities were already developing different approaches:

Again, I think it's quite mixed in that there are inevitably some councils that remain in their old municipal style, but lots of them have tried to break out and adopt new relationships with people in communities in a way that makes a positive difference to places. (Policy adviser A)

3.2.7 Views over the leadership role of local authorities

Interviewees were asked to describe hallmarks of successful public health leadership in local authorities. A key theme was recognition that public health was central to local government combined with clear statements from the local authority over its responsibility in leading on health and wellbeing and its accountability for the public health agenda. This would imply integration of preventive strategies and public health messages into local authority strategic plans and investment strategies. One interviewee commented:

I think a clear understanding that the health and wellbeing of local people is what local government is all about. I think a clear description of the kinds of ambitions that local leaders have for health and wellbeing is tremendously important. And I think a clear articulation of the kinds of actions and expectations from those actions is important... I think continuing to tell a story about what's happening and what's improving is important. (Policy adviser B)

Leadership by elected members was key:

So if you've got a portfolio holder who gets public health, I think you're kind of halfway there. They can champion public health for you, whereas an officer on their own may struggle against competing demands on the local authority. (Local government representative)

It was argued that distinctions between health and wellbeing and the 'overall goal' of a local authority, and debates over what was health and what was not health, could be counterproductive. However, this broad approach would have implications for the membership of the HWB and its reporting arrangements:

And the logic of that would be that then your health and wellbeing board would be seen as a really important committee within the council, regardless of its actual governance arrangements, but it would be vital because that would be the place where you would be thinking in a very broad sense about what made your local authority a good place to live. (Public health representative C)

Key was good political leadership; close working between the DPH and the senior management team; close working with elected members and 'actually persuading councillors to be champions of the agenda'; and mutual understanding across public health teams and elected members of their respective roles and contribution. All of these factors required culture change within local authorities:

I think it's how local authorities think of what they do. So I think it's a big challenge to them to reconsider their role as leading public health and wellbeing in their locality. That's very different from either acting as a voice for local people or simply being in a place that most local services that aren't health emerge from. So thinking about themselves as leading on public health or health and wellbeing for their locality is a really big ask, and I'm not sure that many have really understood that. (Policy adviser C)

Other hallmarks of leadership mentioned by interviewees included the ability to create networks of relationships working towards joint priorities; reducing health inequalities; working and communicating effectively with local communities. Some interviewees focused on the public health leadership role of HWBs rather than of the local authority as a whole.

3.2.8 The health premium

The health premium was considered disappointing and too small to make a difference. Indicators also took a long time to change, although one interviewee thought it helped focus minds 'on the importance of public health in the local authority setting' and another was keen on incentives in principle. However, one interviewee also highlighted potential inequity, as follows:

Sometimes it's the places where the challenges are most easily overcome that secure the premiums or the rewards for good performance. And so areas which have got much more ingrained challenges to public health that are harder to overcome perhaps find it more difficult to demonstrate the impact quickly enough. (Policy adviser B)

4. Discussion

The aim of carrying out interviews with national stakeholders was to provide an overview of the field and identify a range of views over the impact of the reforms on public health commissioning and the leadership role of local authorities. Specifically, interviews were intended to inform research instruments to be used in field work and selection criteria for case study sites. The interviews were not intended to provide detailed examples of innovation in public health services, pooling services or contractual innovation as these will be a focus for enquiry in the fieldwork.

Many of the themes raised by interviewees are familiar in public health policy: the key role of community engagement; the impact of the wider social and economic environment on health; and issues of governance and accountability, including local accountability. Public health services being under threat from acute service demands was a familiar theme prior to the reforms, but the threat is now from financial challenges for local authorities in meeting statutory duties.

As would be expected given the range of interviewees, different themes were highlighted in the interviews. Some HWB members tended to focus on the integration agenda; other interviewees emphasised the potential of the public health role of local authorities and legislative and contractual opportunities created within a local authority framework. Most recognised the variety of local authorities and that such differences were likely to affect the relationship of HWBs with other council committees, their collaborative focus and priorities for discussion.

Some key distinctions emerged. First was the extent to which the transfer of public health responsibilities was framed in relation to the role of the public health team and the public health budget in influencing local authority actions, as opposed to action by local authorities following a change in their statutory role as a result of the reforms. If public health staff were considered mainly in relation to the transferred public health budget, then their role in relation to wider public health challenges could be reduced. There were some indications of the transfer of staff as playing a relatively small part in the dynamic of transformation, which derived from the local authority system as a whole. This led to differences of view over the role and influence of DsPH and over the merits of a ring-fenced budget in a locally-led public health system. While the potential for greater community engagement and responsiveness to community priorities were seen as a key benefit of the transfer of public health responsibilities, this could also lead to tensions between service needs and national public health priorities that might not be prioritised by local communities or elected members.

Second, while the potential of local authority leadership in public health was recognised, some interviewees were sceptical that the cultural change required to lead on proactive engagement of local communities to reduce health inequalities or to maximise the public health potential across the sweep of local authority services had happened in practice. There was a clear distinction between reframing existing work of the local authority as public health and more radical rethinking of the health impacts and health potential of all local authority services. With a sample of just 11 interviewees, it is difficult to draw conclusions over differences of view. However, some interviewees tended to focus more on health and social care; different views were expressed over the breadth and effectiveness of HWBs; and while almost all

interviewees supported the reforms, a wide range of caveats and areas for improvement were discussed.

Third, was a gap between expectations of the reforms and what had been achieved to date. The reforms were considered to make innovation and the spread of innovative practice more likely in areas such as local engagement, contract specification, new providers, holistic approaches and the use of community outreach and community networks. However, there was little evidence of the use of health impact assessment, for example, and the impact of the reforms would be difficult to determine given the effects of austerity, innovative approaches which predated the reforms and concurrent changes, such as certain public health services becoming mandatory. At the same time, changes in reach, extent and impact could be identified.

Although most interviewees found the interview schedule comprehensive (see appendix one), a number of additional research questions emerged as a result of the interviews, including those listed below:

- Identifying ways in which the public health budget has been used as a catalyst and ways in which small levers could create bigger change (and any trade-offs made);
- How and to whom the public health budget is reported at a local level;
- The extent and nature of pooled budgets;
- How local authorities are communicating their public health leadership role and reflecting it across directorates;
- The ways in which contractual and legal support within local authorities is being used to incorporate public health aspects into contracts across the local authority;
- The collaboration at local level (i.e. below HWB level) across general practice and local authorities;
- Support provided to the VCS in engaging with local communities and in developing their evidence base;
- The extent to which needs of underserved groups are being addressed in practice;
- How DsPH see their role in health protection;
- Audit and scrutiny arrangements for public health outcomes;
- The extent to which specific services form part of comprehensive strategies;
- The extent to which HWBs discuss the public health budget, public health outcomes and a broader public health agenda.

As far as the choice of potential case study sites is concerned, a few sites were named as being innovative, and these will be considered in relation to other selection criteria: it was also emphasised that a rural area needed to be included as well as authorities under different political control. While it is anticipated that field work will identify innovative practice, as well as the analysis of outcomes and spend, interviewees also mentioned the potential for more collaboration across local authorities in relation to public health challenges and how to address them. The project will aim to provide comparative information which will contribute to this aim.

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Appendix one: Interview Schedule for national stakeholders

Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision

Introduction to interview/preamble

Background to the project

This research project, entitled '*Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision*' is funded by the National Institute for Health Research (NIHR) Department of Health Policy Research Programme. Its purpose is to evaluate the public health reforms which directly result from the implementation of the Health and Social Care Act 2012. The study, led by Durham University, takes place over two and a half years.

Background to interviews

These interviews form the first stage of the project and are intended to explore views of a wide range of stakeholders with a national perspective on key issues arising from the transfer of public health responsibilities to local authorities. It is intended that this will provide an up-to-date overview of key issues and inform both the selection of case study sites and key themes for detailed study. The interview will cover the following main topics:

- Innovation in commissioning preventive services including lifestyle management services and the NHS health check
- The leadership role of local authorities in public health.
- The transfer and use of the public health budget

Interviews are taking place in February and March 2015, and a report will be produced in April 2015.

Interview process

The aim of this interview is to find out about your personal views or experiences. Ideally, we would like to record the interview and then transcribe it in full through a professional agency. The transcript will be anonymised and your identity will be kept confidential.

Are you happy with this arrangement and do you have any questions about the study or the process before we start?

A. Background

A1. Could you describe your current role?

A2. Could you briefly describe how your organisation engages with local authorities in their public health role? (for non LA interviewees)

- Information/advice?
- Support?
- Analysis?
- Other?

A3. Could you briefly describe your involvement with local authorities in relation to their public health role?

- Who or what were you involved with?
- What was the nature of this engagement?

A4. What was your view of the public health reforms at the time of the Health and Social Care Act in 2012?

Advantages?

Disadvantages?

A5. Has this view changed at all since implementation of the Act in 2013?

- If so, why?

A6. In general terms, what do you consider the main ways in which local authorities can address social determinants of health and of health inequalities in their areas?

Have the reforms made this easier, more difficult or no effect?

What are the main constraints facing local authorities in this area?

A7. In general terms, what do you consider to be the main ways in which local authorities can improve access to preventive services?

Have the reforms made this easier or more difficult?

A8. In your view, have the reforms made it more likely that locally-identified public health issues will be addressed?

Through what mechanisms would they be identified?

Through what mechanisms would they be addressed?

A9. What do you understand by the phrase ‘public health commissioning system?’

A10. Which kinds of public health commissioning support need to be provided to DsPH and local authorities by other organisations?

- Role of PHE?
- Role of NHS England Local Area Teams?

A11. From your experience can you indicate ways in which the current public health commissioning system could or should be improved?

- Funding?
- Coordination across CCGs, LAs, other agencies, as well as within LAs?
- Health protection arrangements?
- Stronger evidence base for public health interventions?
- Governance arrangements
- Other?

A12. Are current arrangements for health protection adequate in your view?

A13. What do you see as the three main barriers facing local authorities in fulfilling their public health responsibilities?

B. Commissioning preventive services

The second set of questions looks at preventive services.

B1. What do you consider the main differences between how the NHS commissioned preventive services and approaches being adopted by local authorities?

- Approaches to commissioning and the commissioning cycle?
- Less emphasis on public health evidence base / use of different types of evidence/intelligence?
- Less emphasis on lifestyle services / greater emphasis on wellbeing?
- Increased efforts to address the social determinants of health?
- Democratic accountability?
- Different approach to targeting services?
- More emphasis on asset-based approaches
- Working through different local authority agencies?
- Remodelling of services?

B2. Have the reforms made it easier or more difficult to collaborate on:

**Commissioning preventive services?
Commissioning across pathways/agencies?**

B3. Do you consider that new public health responsibilities are encouraging innovation in public health services? If so, which kinds of innovation?

- Innovation in the **provider** landscape?
- New configurations of **providers** (LA, community/CCG/ other)
- Innovative services by **providers**?
- Development of new models of provision/combining services?
- Innovation in **co-design** of services?
- Innovation in **targeting** strategies (e.g. clustering of behaviours)
- Innovative approaches to proactive case finding?
- Earlier intervention
- Innovation in developing and using **community networks**/ peer support/volunteering/befriending?
- **Incentives** for improved outcomes?

B4. Have the reforms encouraged (or necessitated) the use of new providers for preventive services?

- Voluntary and community sector?
- Public sector?
- Private sector?
- Community networks?
- Other

B5. Have the reforms encouraged greater involvement of the public in co-design of preventive services? Examples?

**Children and young people's involvement?
Involvement of different age groups?**

B6. Have the reforms led to increases in uptake of preventive services by those least likely to use them?

**If so, how has this been achieved?
If not, have the reforms led to decreases or has uptake stayed the same?
In other words, is there a risk of widening the inequalities gap?
Examples?**

B7. Focusing on some specific public health responsibilities related to lifestyle services, can you provide any examples of the impact of the reforms on the following:

Childhood obesity?

Lifestyle management services (weight management, physical activity, smoking cessation, alcohol counselling)?
Health checks programme and follow on services?
Sexual health services?

B8. *In your view, what should be the main influences on the kinds of preventive services local authorities commission?*

- *LA knowledge of local communities?*
- *Local relevance*
- *Public health team?*
- *Community networks?*
- *Local Healthwatch?*
- *Local politicians?*
- *HWBs?*
- *Joint Health and Wellbeing Strategies?*
- *CCGs and NHS providers?*
- *Evidence base?*
- *NICE local government briefings?*

B9. *How influential is the public health outcomes framework in influencing commissioning priorities?*

B10. *How would you like to see performance measured in relation to public health responsibilities?*

B11. *How influential is the public health team in relation to the following:*

- Commissioning preventive services in local authorities?**
- Preventive initiatives commissioned by CCGs?**
- Coordinating preventive initiatives across CCGs, LAs and other agencies or sectors (e.g. the voluntary and community sector)?**

B12. *What do you consider as the main barriers and enablers for commissioning effective public health services?*

B13. *Have you any comments to make about changes you would like to see in commissioning arrangements?*

C. The third set of questions concerns the broader public health leadership role of local authorities

C1. In your view, what are the hallmarks of successful public health leadership in local authorities?

C2. How can local authorities further develop their role as leaders of a public health system? What needs to happen?

- Changes in partnership arrangements/boards?
- Changes in accountability arrangements?
- Incentives?
- More emphasis on commissioning across agencies?
- Developing local responsiveness?
- Achieving greater devolution?
-

C3. Are you aware of authorities which have reflected their new public health role in

Developing public health commissioning initiatives which span different local authority directorates?

Broader membership of HWBs

Joint health and wellbeing strategies which span social determinants of health

Deployment of mainstream budgets?

Place-based initiatives?

C4. Are you aware of authorities using health impact assessment or health equity impact assessment as part of their decision-making process?

C5. How much influence do DsPH and public health teams have over local authority budgets?

- Transport?
- Leisure?
- Housing?
- Other?

C6. How much scope is there for Directors of Public Health to exercise an independent voice in the new system?

- Role of the independent report of the Director of Public Health?
- Independent advice?

C7. What do you consider to be the main challenges facing local authorities in developing a local public health system?

D. The fourth section considers the ring-fenced public health budget

D1. What do you consider the main influences on the deployment of the ring-fenced public health budget?

- Public health team?
- Public health interventions evidence base?
- Return on investment arguments?
- HWB and JHWB strategy?
- Historical spend?
- Pressures from other services?
- Potential as a catalyst for encouraging preventive aspects of other local authority services?

D2. What are the main tensions in deploying the budget?

- NHS historical use versus current local authority priorities?
- Difficulty in prioritising public health interventions?
- Different understanding of what constitutes legitimate use of the budget?

D3. In your view what should be the main influences?

D4. How important do you consider the distinction between mandated and non-mandated public health services in commissioning priorities?

D5. Are you aware of any pooling arrangements across the public health budget and other services?

What are the advantages of pooling arrangements?

What are the disadvantages of pooling arrangements?

D6. In your view how can LAs best maximise their use of the ring fenced public health budget?

D7. How should PH spending be reported ?

Audit arrangements?

D8. What is your view of the health premium as an incentive?

E. Finally we would like to ask you for your views over the future development of this study. We are selecting 10 case study sites for detailed study.

E1. Are there local authorities you are aware of who have developed innovative approaches in relation to any of the areas discussed above?

Childhood obesity?

Lifestyle management services (weight management, physical activity, smoking cessation, alcohol counselling)?

Health checks programme and follow on services?

Sexual health services?

E2. Are there any additional questions you would like to see pursued through our research?

E3. Are there specific dissemination routes you would like to see us pursue?

E4. Are there any sources of information/documents we should be aware of?

E5. Finally, are there any other issues you would like to raise or any comments you would like to make about the interview questions or the interview process?

Thanks etc