The English local government public health reforms

An independent assessment

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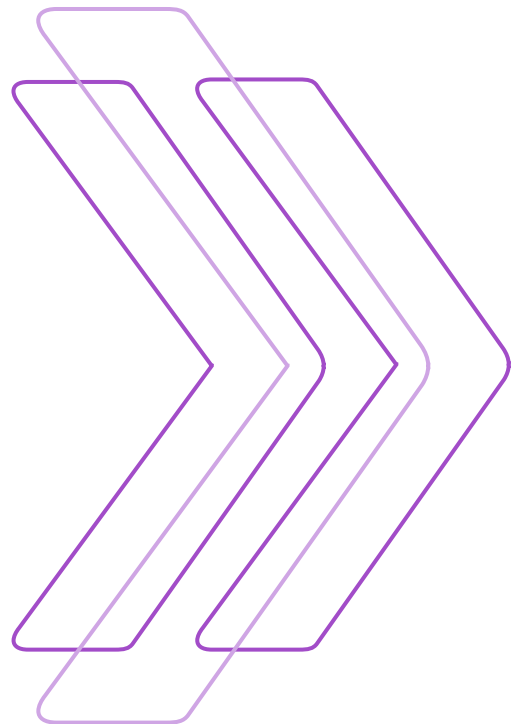
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Executive summary

Significant public health functions were transferred to local government from the NHS as part of the Coalition government's health and care reforms. Enough time has now passed to provide an overall assessment of the impact of these reforms. The reforms transferred the commissioning of some specific functions and a ring-fenced budget to local government, ranging from smoking cessation services through sexual health services to obesity prevention while retaining some clinically focused services, such as immunisation, in the NHS.

But the reforms also had a wider purpose, for public health teams to influence and support wider local government decisions that impact the public's health, given the strong evidence that while the NHS has a significant role to play, much of what determines health – including good-quality homes, access to stable and rewarding work, safe and secure streets and a good environment – are influenced more strongly by local government.

Our overall view is that the move to local government for many public health services was the right one. More important still, in the long term is the opportunity this has to influence wider local government policy and decisions; now is the time to make good on the opportunity in the context of the development of place-based population health systems.

The reforms, however, coincided with austerity where local government funding, in the specific public health grant and more widely, was not prioritised by the government compared to NHS funding, receiving real-terms cuts from central government. There now needs to be an increase in funding from central government, at least an additional £1 billion for the public health grant every year from 2020/21, to keep pace with population growth and inflation.

Early assessments of the reforms

Early assessments of the reforms focused on the process of transition itself. This was a major organisational and cultural challenge for staff involved, local government and the NHS. Challenges included the significant loss of staff, including directors of public health, early on following the transfer (such as through early retirement) and high vacancy rates in the early days but

surveys by the Association of Directors of Public Health were positive, with almost 70 per cent of respondents thinking that having public health in local government would improve population health outcomes.

The reforms were subject to much scrutiny by parliamentary committees, which focused on clarifying issues of accountability, the role of health and wellbeing boards, and the role of local 'sector-led improvement' in assuring progress versus central assessment by Public Health England or others; and worries about the potential end of ring-fenced funding.

An array of published case studies showed much innovation, while multiple survey-focused academic and other studies pointed to similar findings including:

- improvements in the effectiveness and equity of commissioning and significant innovation

- increased potential for integration between public health and wider government functions that affect health

- risks of fragmentation in commissioning and provision for some services where there were strong links with NHS pathways of care

- some loss of input into NHS decision-making

- significant worries about the future impact of central government-imposed cuts to ring-fenced public health and wider local authority budgets.

The long view of the reforms

The impact of the reforms cannot be interpreted without considering the cuts to the ring-fenced budget from mid-2015 onwards and the wider and more damaging cuts to overall local government spending. The National Audit Office reports that local authorities have seen a 49 per cent real-terms cut in central government funding between 2010/11 and 2016/17 and an overall 28.6 per cent reduction in their spending power. This is the context in which the findings below need to be judged.

The reforms have led to significant innovation and integration and some fragmentation. There is good evidence of positive innovation in the services that moved to public health, through stronger commissioning and the modernisation of services, for example, online testing for sexual health.

Public health teams have integrated well into local government, influencing policy at both local and regional level. There are many well-known case studies and examples of this (*see* main text), and survey studies support it. However, this integration has tended to be more in 'people' functions (for example, children's services and social care) as opposed to 'place' functions (for example, economic development and planning).

However, there has been some fragmentation of commissioning and provision, particularly in those service areas that are interlinked with NHS provision, for example, sexual health, and drug and alcohol services.

Overall, The King's Fund supports the government's recent review which concluded that the responsibility for these services are in the right place, but also that there needs to be much stronger joint commissioning of these services between local government and the NHS. This, with associated mechanisms such as pooled budgets and rewards sharing, will also help tackle the 'incentive trap' for local government innovation; that much of it 'pays off' in the NHS, not for local government itself.

In theory, much of public health activity through the grant, and through the wider role in local government and systems should be highly cost effective (based on many academic studies and the work of the National Institute for Health and Care Excellence, Public Health England and others).

In practice, there has been an absence of high-quality studies that have shown the actual impact of the reforms on health outcomes. However, recent analysis by the University of York suggests that the expenditure through the public health ring-fenced grant is three to four times as cost-effective in improving health outcomes than if the same money had been spent in the NHS baseline.

What we do know is that there are reports of services being reduced or cut, and this is likely to have an impact on individuals or groups of patients, while more broadly Local Government Association analysis of recent trends in the Public Health Outcomes Framework indicators showing that 80 per cent improved or were unchanged in the financial year to 2018.

Looking to the future

Public health team and partners have been operating within ever-shrinking budgets. By the end of 2020/21, The King's Fund and the Health Foundation

estimate that, with population growth and inflation factored in, the ring-fenced grant requires £1 billion per year extra funding to restore it to 2015/16 levels. Changes to local government finance mechanisms (for example, the intention to increase local retention of business rates) need to be implemented in a way that does not unintentionally put public health spending and outcomes at risk.

There are opportunities for a greater focus on prevention in the NHS long-term plan and the government's prevention consultation paper. But the NHS and central government need to ensure that these changes are consistent with the wider context, a shift to place-based population health systems, where local government is a key player.

The public health reforms in local government are now embedded and with more stability, at least over funding, more attention now needs to be paid to outcomes and tackling unjustifiable variation. More effort is required to understand how local government public health efforts change population health outcomes including: understanding the contribution to change in complex systems; benchmarking and productivity between local areas; and more effort by the National Institute for Health Research and others to support evaluating practice 'on the go'.

Public Health England needs to do more to support local government to define, diagnose, and tackle unjustifiable variation in practice and impact on population health outcomes (taking into account differences in resources). It has the data and intelligence to do so and, with the support of the LGA, the NHS and other partners, needs to use them more actively.

Personal and institutional leadership will be critical in shaping successful place-based population health systems. Directors of public health and public health staff have the skills and position to be at the heart of this, both within local authorities to influence 'place' functions and beyond to help shape cross-sector strategies locally and regionally.

Institutionally, health and wellbeing boards can also play a part but to do so they will need to have a focus on place and committed leadership that is able to influence across the council and into the NHS, including working with integrated care systems (ICSs) and primary care networks (PCNs) as they develop.

1 Introduction

This paper sets out an assessment of the English 2013 reforms to public health, which were part of the Coalition government's wider health reform programme. Enough time has passed, and enough insight has now been published to make such an assessment possible.

Famously, the incoming Secretary of State for Health, Andrew Lansley had a fully worked-up view on future NHS reform as he came into post in 2010 (Timmins 2012). What is much less well known was that his personal interest was in public health reform, indeed at one point it was his intention to rename his Department, the 'Department of Public Health' (Timmins 2012, p37).

As it turned out, the public health reforms, although highly significant in themselves, stayed largely under the radar compared to those in the NHS which then NHS chief executive, David Nicholson, said were 'so big you can see them from space' (Ham *et al* 2015, p 10). The public health reforms did not, and have not, received as much attention as they deserve. This report aims to help address this by setting out an independent view of the reforms themselves, considering both the context in which they took place and the changing context over time. It draws on a wide range of evidence and views.

The focus is on the local government part of the reforms, and, within that, on health improvement and the wider determinants of health. This assessment does not cover health protection, and it does not focus on the NHS role in public health, except where this is relevant to the relationship and role of local government. For more on how the reforms affected health protection *see* Smith *et al* (2017) and on health care public health *see* Association of Directors of Public Health *et al* (2017).

This document is structured as follows. Section 2 provides a quick run through of the 2013 public health reforms and the Coalition government's reasons for introducing them. This is followed by a review of early views of the reforms in Section 3 with a focus on transition from the previous system and embedding relationships. Much of the source material for this section comes from parliamentary select committees and related investigations. Section 4 looks at the longer-term impact in the context of cuts in funding, with a focus on innovation, integration (or otherwise) and on health outcomes. Section 5

looks to the future, including implications of the NHS long-term plan, the prevention 'Green Paper' and the wider shift to population health systems. A short final section draws conclusions.

Finally, unless otherwise indicated when we refer to 'the government' or 'central government' this means the Coalition and subsequent administrations since policy towards public health has been consistent across them.

2 The 2013 public health reforms: a quick guide and timeline

The public health White Paper

The White Paper, *Healthy lives, healthy people* (Department of Health 2010), set out the government's plans for public health reform, in which local government's role was key.

In short, the government's view was that,

> *To… avoid the problems of the past, we need to reform the public health system. Localism will be at the heart of this system, with responsibilities, freedoms, and funding devolved wherever possible.* (Department of Health 2010, p 8)

Key elements of the reforms to be introduced were:

- directors of public health as the strategic leaders for public health and local inequalities locally

- ring-fenced public health funding for upper-tier and unitary local authorities, carved out from the NHS

- a Public Health Outcomes Framework (PHOF), with greater transparency of outcomes published locally and nationally

- a 'health premium' to reward local authorities for performance on the Public Health Outcomes Framework, taking into account health inequalities

- the Cabinet Sub-Committee on Public Health would co-ordinate work across multiple departments to address the wider determinants of health

- the creation of Public Health England as part of the Department of Health but with some independence, with a focus on emergency preparedness, health protection, public health campaigns and supporting the local system with data, tools and evidence

- a new 'Responsibility Deal' reflecting that businesses must take more responsibility for the impact of their practices on people's health and wellbeing

- a new National Institute for Health Research (NIHR) School for Public Health Research and a Policy Research Unit on behaviour change

- some elements of public health remaining as part of the NHS Commissioning Board's (now NHS England) mandate, for example, vaccinations and immunisation; stronger incentives for GPs to play a more active role in public health

- the Chief Medical Officer to remain as the chief advocate for public health across government and the leader of the professional public health network.

In essence, the reforms dismantled the machinery of national public health and health inequalities targets delivered across government[1] (with a focus on the NHS contribution towards the end of the Labour government's time in office) and replaced this with a stronger focus on incentives, voluntary agreements with industry and localism led through local government, supported by stronger evidence and a central public health organisation with powers focused on health protection and emergency preparedness.

This was to be achieved through a new Health and Social Care Act, which would also introduce related reforms, including the creation of health and wellbeing boards (HWBs), and wider reforms to the NHS.

The Department of Health consulted on the detail of the White Paper itself and, in linked consultations, on the scope of the PHOF and the funding and commissioning of public health (Department of Health 2011a).

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[1] There were tensions under this regime, including worries over NHS primary care trusts raiding public health spending to prioritise hospital services as pointed out by the Chief Medical Officer, Sir Liam Donaldson (Department of Health 2006). Perhaps surprisingly, there have been few direct assessments of the Labour administration's approach to public health and health inequalities, the most detailed published by the Department of Health itself (Department of Health 2009).

The response and the outcome

Overall – and in stark contrast to the proposed NHS reforms – the response to the proposed public health reforms was positive and supportive. Most stakeholders supported the main feature of the reforms – giving local government a stronger role and more powers for public health – acknowledging the greater control and influence that local government, rather than the NHS, has over the wider determinants of health.
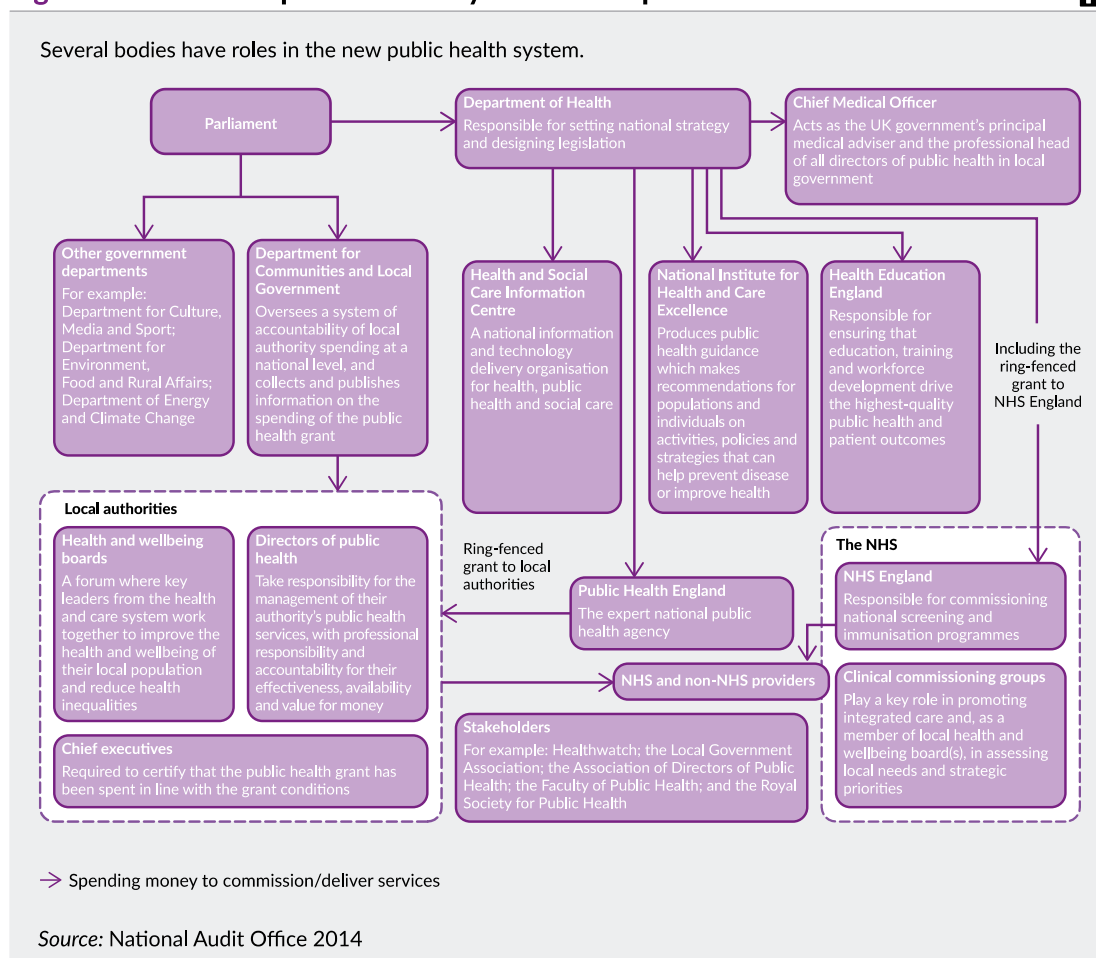
Nonetheless there were concerns raised including:

- the status of Public Health England. Some – including the Faculty of Public Health – argued that to be effective Public Health England needed to be more independent of the Department of Health than its Executive Agency status provided, especially in telling truth to power (Department of Health 2011a, p 88)

- the public health advice relationship with the NHS, including the role of general practice (Department of Health 2011a, p 70)

- ensuring that relevant data continued to flow between the NHS and local government (Department of Health 2011a, p 80).

The King's Fund's agreed with the principle of the reforms (The King's Fund 2011) and that, on balance, Public Health England 'needs to be a part of government in order to wield the influence it needs to on public health' (The King's Fund 2011, p 5). However, it argued that the reforms left public health in a half-way house. On the one hand, the reforms gave a strong signal that what really mattered locally was the population health outcomes that are achieved, and that the centre could not know enough about local circumstances to determine which mix of services, policies and regulatory actions would make sense locally to achieve this. On the other hand, local government was given a list of prescribed services that it had to deliver; and a public health budget ring-fenced from other local government funding. The Fund's view was that the mix of policies supporting the reforms were not therefore entirely consistent.

The local government public health system

The National Audit Office summarised the public health system roles introduced by the reforms (*see* Figure 1).

Figure 1 Roles in the public health system from April 2013 [K]

Several bodies have roles in the new public health system.

→ Spending money to commission/deliver services

Source: National Audit Office 2014

The reforms placed specific responsibilities on local authorities for functions they would be responsible for commissioning and be provided with the funds, transferred from the NHS, for doing so (*see* Table 1). The Coalition government set out its rationale for transferring many of these services in its consultation on the reforms, and made some changes following that (Department of Health 2011b), particularly due to concerns raised about fragmentation of service commissioning and provision. There remains disagreement and debate about some services, particularly those that are closely intertwined with services that remain in the NHS and include elements of clinical treatment, such as sexual health and substance misuse services (*see* Darzi *et al* 2018 for example). We will return to a consideration of these issues.

Table 1 Public health services and functions that transferred to local government, or remained within the NHS following the Health and Social Care Act 2012

Transferred to local government	Remained within the NHS
NHS Child Measurement Programme*	Child health information systems
Prescribed children (0–5 years) services*†	Cancer screening programmes
Child (5–19 years) public health programmes	Immunisation programmes
NHS Health Check programme*	Non-cancer screening programmes (e.g. newborn hearing screening programme)
Sexual health services (STI testing and treatment, contraceptives and advice on preventing unintended pregnancy)*	Prison health services for adults and children
Sexual health services (advice, prevention and promotion)	Sexual assault referral services
Obesity programmes (adults and children)	
Physical activity programmes (adults and children)	
Public health advice and support for NHS commissioning*	
Stop smoking services and interventions	
Wider tobacco control	
Substance misuse (drugs and alcohol services)	
Local authority role in health protection*	

*Prescribed functions that need to be delivered in a standardised way; or available to all; or are delegated from the Secretary of State for Health and Social Care.

†Came into effect on 1 October 2015 – includes universal health visiting services and targeted support such as the Family Nurse Partnership (HM Government, 2013; for a full list see Appendices A and B).

Source: Davies *et al* 2016

But beyond this, the intention was to maximise the wider impact of local government and wider spending and actions on health, given that local government has a stronger understanding of the overall social, economic and environmental conditions that influence the health of local populations, and has more powers and ability to influence them than the NHS. A holistic approach to public health locally would therefore see the roles and responsibilities as a core set but the intention was to move far beyond this, to influence wider local government decisions and reach out beyond the organisations and structures in Figure 1 (p 14), maximising the impacts of other central government agencies and local delivery arms and agencies, the voluntary and community sector, businesses and civic society on health.

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Further change

There have been few further public health reforms specific to local government, and those that there have been were signalled and planned for. But public health has been caught up in the further development of the government reform process, particularly the move away from central government grant funding to more locally retained business rate funding.

The biggest extant change has been the transfer of public health services for children aged 0 to 5 to local government mid-way through financial year 2015/16 (Department of Health 2014). At the time of writing the Department of Health and Social Care has consulted on, but not responded to, whether the current list of prescribed services needs to be changed (Department of Health and Social Care 2018) and it is still unresolved whether, and if so how, the ring-fenced public health grant will be included in the greater shift to retained business rate funding (Cabinet Office and Department of Health and Social Care 2019), which several areas including Greater Manchester are currently trialling (Local Government Association undated a). As is usual practice in health allocations more generally, the Advisory Council on Resource Allocation has also periodically looked at and adjusted the resource allocation formula for the local government public health grant (Department of Health 2015).

3 Early assessments of the reforms: transition and embedding relationships

Despite most debate around the health reforms being focused on the NHS, there were some initial assessments of the public health reforms. Understandably, many of these were focused on the transition of responsibilities from the NHS to local government.

The view from the ground

The early assessments of the reforms from professional organisations representing those most affected by them focused on the views of the workforce, in terms of their roles, responsibilities, ability to influence decisions and wider concerns about funding.

Directors of public health and wider public health staff

Directors of public health were central to the reforms, holding the ring-fenced budget but also occupying one of very few statutory seats on health and wellbeing boards, thereby influencing wider local authority priorities and other key local organisations on, or represented by, the boards including the NHS. The Association of Directors of Public Health (ADPH) surveys of directors of public health are therefore an important source of evidence on how the reforms were perceived.

It is important to note that although this was a significant upheaval for many directors of public health and their teams who had been located solely in the NHS since the mid-1970s, for some it was more of an evolution. Joint director of public health appointments were already possible and were supported, especially where NHS primary care trusts (PCTs) were co-terminous with local authorities and experience was positive (*see* Hunter 2008 for a review of this experience).

ADPH surveyed its members regularly from November 2011, well before the transition and continues to do so. The surveys are sent to all directors of public health and have high response rates of around 75 per cent. Views

expressed in October 2013, six months on from the implementation of the reforms, focused on the transition of staff from the NHS to local government and the loss of experienced directors of public health (17 in the previous 12 months). These losses resulted from retirements and shifts between councils, but mainly from moves to roles in Public Health England (Association of Directors of Public Health 2014). The survey results showed '…a continuing and worryingly high numbers of vacancies (35 posts, 27 per cent)'. The data suggested that, given further retirements and other plans, the system needed to recruit at least 48 directors of public health over the following 12 months and that, 'This level of continued turnover represents a considerable risk to the public health system.'

After the reforms, directors of public health were entering local government at a time of considerable change, with many local authorities restructuring. This meant the model for where public health 'sat' was very varied and subject to change. In 2013, half of respondents reported directly to the local authority chief executive, with the rest reporting to other directors.

Despite these challenges directors of public health reported improved engagement with the council, and 80 per cent said that their council had a clear vision for public health (up from 66 per cent 12 months previously), 90 per cent reported appropriate access to councillors, and 67 per cent said that they had appropriate influence across council directorates.

Three-quarters reported day-to-day control over the ring-fenced budget, although some were concerned that, along with other council budgets, the public health budget was being squeezed and in some cases was being expected to cover services that had an impact on public health that were previously provided from other spending lines. However, 15 per cent said that their council was spending more than the ring-fenced grant.

Almost 70 per cent of respondents thought that having public health in local government would improve population health outcomes but there was worry about the overall reduction in local government resources, the possible inequalities impacts of welfare reform and the wider economic downturn having a negative impact on health outcomes.

The Royal Society for Public Health published its survey of public health teams one year on from the reforms (Royal Society for Public Health 2014). It included a wider spectrum of more than 200 respondents including

consultants, specialists and health improvement practitioners as well as directors of public health, reflecting the society's membership.

Unsurprisingly, given the time lags involved, at the time of the survey few (15 per cent) thought that the move had led to improvement in health outcomes, more worryingly more than half (52 per cent) were unconvinced that the move would result in a reduction in health inequalities and an improvement in public health. There were concerns about the availability of evidence to show return on investment to local authorities and about the ring-fence, with more than half of respondents (53 per cent) thinking it was a ring-fence in name only.

However, most respondents agreed they had access to key decision-makers and that the public health department was working closely with other local authority departments; and a large majority agreed that the move would be good for community engagement in decisions, reflecting the perception that local authorities were better at this than the NHS.

The rest of local government

The New Local Government Network (NLGN) surveyed senior local government officers and undertook interviews and site visits about how well public health was being embedded in local government (Mansfield 2013). Overall, the research found that both public health teams and other key staff in councils were positive about the change, and 80 per cent (of 166 respondents) said that public health priorities were beginning to reflect action on the wider determinants of health and the contribution of local authorities' wider functions. Where the transition had been judged to go well, this was due to the leadership of the director of public health, their skills in committee working and the support of elected members.

However, most respondents thought that there had been challenges and the organisational change from the NHS into local government had not been easy. Despite a clear impact on local government priorities, these were not yet reflected in changes in spending, due to the carry-over of existing contracts. Further, public health teams that had been transferred over into local authorities on a 'lift and shift' basis were felt to be more isolated than bedded out teams that were judged to be more integrated with the wider work of the council. The most difficult part of the transition for public health teams was adapting to the culture of local government, the accountabilities to councillors, and the public. In short, 'the political dynamic… is the most difficult'

(Mansfield 2013, p 17) and some directors of public health had found the change from being a decision-maker to a trusted adviser challenging.

Finally, the LGA published a short report nine months into the changes (and follow-ups in later years) based on 16 case studies (Local Government Association and Public Health England 2014). It reported a strong welcome for public health teams in local government, strong relationships with clinical commissioning groups (CCGs), with the public health team an important broker with the wider local authority, and a greater emphasis on asset-based approaches to health and the wider determinants. Challenges included the steep learning curve of working with elected politicians and the emerging problems of maintaining a focus on public health in the face of the slowdown in funding in local government and the NHS, and the impact of the recession on the health of the poor.

The report also supported the ADPH findings, of a wide range of different approaches to the role and 'siting' of public health teams, examples included: other council departments taking responsibility for some of the PHOF indicators; competitive bidding for parts of the public-health grant tied to delivering specific outcomes; hub-and-spoke models with staff embedded in other directorates; the public health team and director of public health taking on wider roles related to the wider determinants of health (eg, leisure and licensing and roles such as deputy chief executive). In two-tier areas some county councils were delegating grants and commissioning to district councils or working jointly on issues such as housing as well as having district representation on HWBs.

The role of health and wellbeing boards

The Coalition government saw HWBs as critical to the whole health reform process – they were intended to be the 'place' where the key strategic decisions that would affect the public's health locally would be taken.

The King's Fund published the first broad view of HWBs based on experience of supporting several of them in the shadow year before they went live, and a wider survey with responses from more than 50 areas on their experience (Humphries *et al* 2012) and returned to them after one year of operation (Humphries and Galea 2013). This latter study focused on HWBs' role in local health and social care integration. The findings were generally disappointing. However, the news was better for public health. Based on the response of 70 HWBs (46 per cent), the highest priorities in the health and wellbeing

strategies of most boards concerned public health and health inequalities, including the principles of the Marmot review (Marmot *et al* 2010) (*see* Figure 2).

Figure 2 Priorities agreed by health and wellbeing boards

Sample size: 65 responses – respondents mentioned more than one priority in most cases

Source: Humphries and Galea 2013
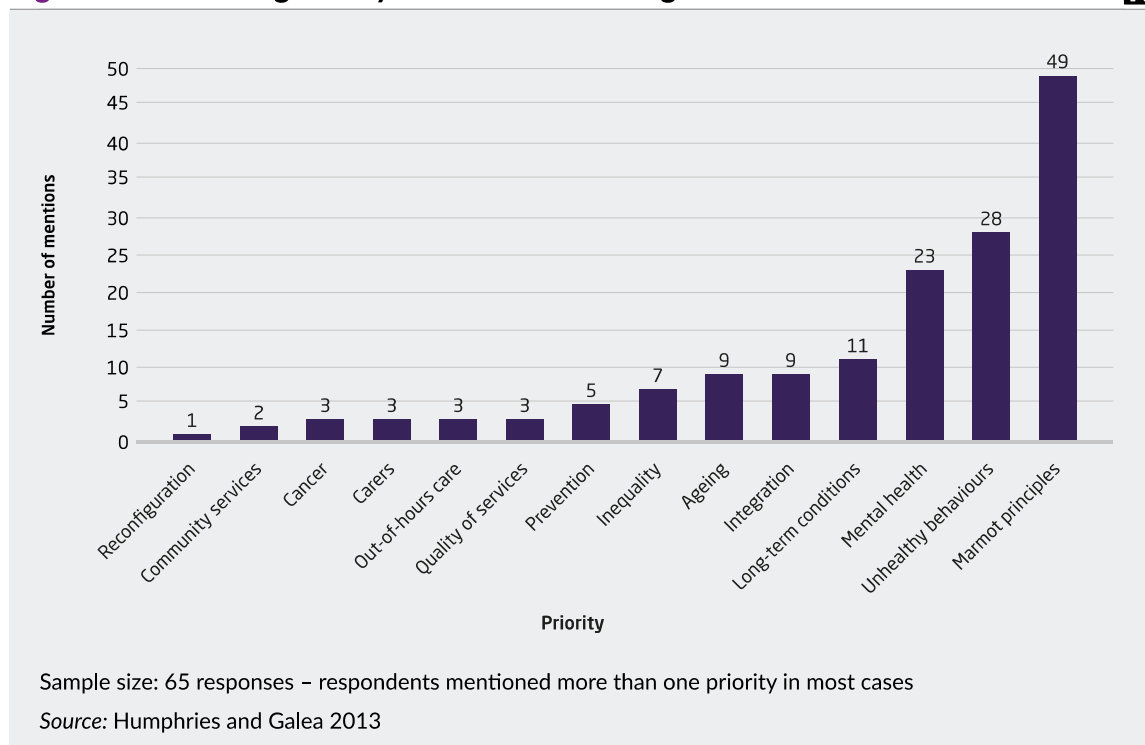
Overall though, the authors suggested that based on the then trajectory most HWBs would default to being reactive to plans from partners, some would make progress overseeing specific public health programmes, but few seemed to be in a position to oversee and lead wider strategic local system change. Some of this may not have been helped by the change in priorities in the Department of Health. In September 2012 Andrew Lansley was replaced by Jeremy Hunt as Secretary of State and his priorities were shaped by the Staffordshire Hospital Scandal and strong attention to patient safety (Triggle 2018) as opposed to the strategic direction of Lansley's public health and wider reforms.

Since then the LGA has commissioned a series of assessments of HWBs (Local Government Association undated b) on an annual basis. They validate the views of (Humphries and Galea 2013), finding that the public health function had settled well into HWBs, but that over time the focus should move towards tighter prioritisation and focus on the 'big issues' and becoming true local

system leaders. The 2016 assessment suggested this had started to change with more evidence that HWBs were played a stronger leadership role but that:

> *Ironically this step change in the performance of some HWBs has coincided with the emergence of a more muscular top down approach by NHS England. This is reflected in the introduction of sustainability and transformation plans which introduce an alternative focus for system leadership across a larger geographical footprint.*
> (Shared Intelligence 2016, p 2)

In response to this, the 2017 assessment suggested that a significant number of HWBs had started to:

> *…reassert a focus on the wider determinants of health and exercise a place leadership role. They are acting as the anchors of place in a sea of Sustainability and Transformation Partnerships (STPs), integration and new models of care.*
> (Shared Intelligence 2017, p 3)

The latest publication on HWBs from the LGA takes an in-depth look at 22 of the 153 HWBs based on the LGA's relationship and support with these areas (Local Government Association 2019c). The LGA draw out several themes from these successful boards: they act as 'anchors of place', influencing other partners through their connections with communities and understanding of needs; add strategic direction to integration, for example, supporting emerging structures such as primary care networks to align with existing integrated community teams; bring prevention into integration, for example, a focus on the wider determinants of health, not just mitigation of illness; and provide strong challenge and oversight.

In summary, HWBs have been a place, partly due to the privilege of having a statutory seat, where public health has been strongly represented. However, there have been doubts about how muscular HWBs have been as strong local system leaders, and how much focus the Department of Health and Social Care, and in turn NHS England, has had in supporting them in this role over time. This has limited the potential of public health teams to influence the bigger strategic decisions that affect the local population's health. There may be some signs that this is changing in some places, with good examples of some HWBs taking strong strategic leadership roles. We will return to the future of HWBs as institutional leaders in section 5.
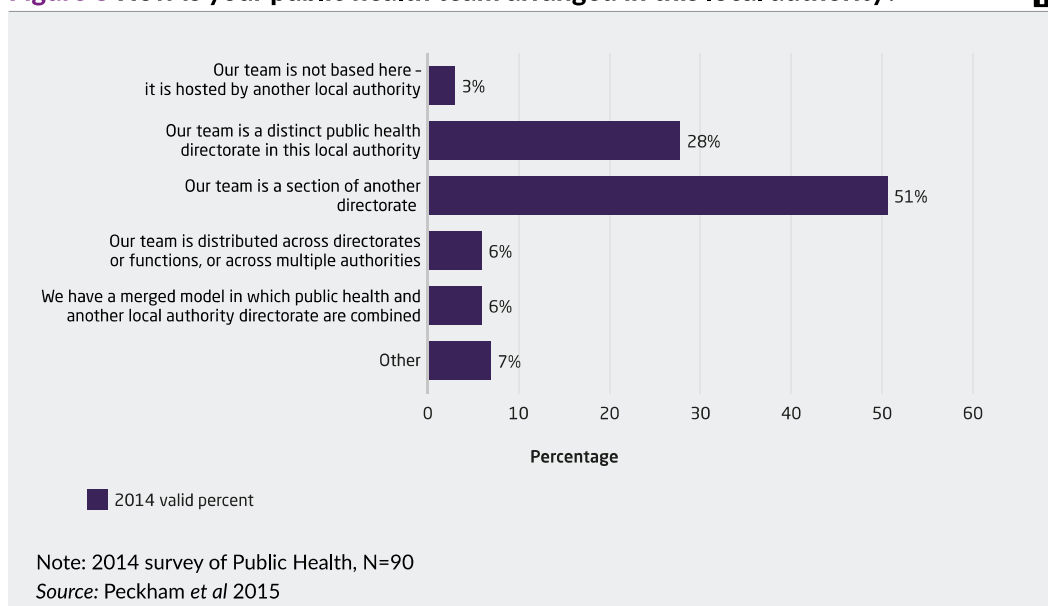
The view from academia

It is not surprising that there was a longer lag in academic assessments of the public health reforms and associated changes. Hunter (2016) sets out an early view, including a good summary of the rationale for change. Several papers have been published sharing the findings of a three-year research project that examined the impact of structural reforms on the functioning of the public health system in England (Peckham *et al* 2017; Peckham *et al* 2015; Jenkins *et al* 2016) based on five case studies (more than 100 interviews and observed meetings) and two national surveys of directors of public health and elected councillors, undertaken between 2013 and 2015.

This looked in depth at where directors of public health and their teams 'ended up' following the processes of change observed by the ADPH and LGA (*see* Figure 3). Half of public health teams were hosted in other directorates, a quarter were stand-a-lone, with the remainder distributed in a range of other models including combined functions and out-posted staff.

Just under half of respondents said they reported directly to the chief executive, and half also reported they had gained additional responsibilities from other parts of the council. This can be interpreted as greater influence but also as stretching resources. Looking forward, many directors of public health were expecting further re-structuring and reduction in the sizes of their teams because of imminent funding cuts. Between 2014 and 2015 there was little change, except a tendency for a merged model, up from 6 per cent to 11 per cent (Peckham *et al* 2017).

Figure 3 How is your public health team arranged in this local authority?

	Percentage
Our team is not based here – it is hosted by another local authority	3%
Our team is a distinct public health directorate in this local authority	28%
Our team is a section of another directorate	51%
Our team is distributed across directorates or functions, or across multiple authorities	6%
We have a merged model in which public health and another local authority directorate are combined	6%
Other	7%

■ 2014 valid percent

Note: 2014 survey of Public Health, N=90
Source: Peckham *et al* 2015

Beyond where they 'sit' and changes in responsibilities, the overall views of public health officers were that the relationship between them and elected members was good and reciprocated. It clearly took time for public health teams to adjust to their new situation in local government but survey responses from directors of public health and elected members showed that public health advice was respected and trusted, with a focus on data analysis and needs assessment, commissioning and health inequalities.

Some of the case study sites had a much more 'health in all policies' approach, over and above behaviour change, than others. However, only one in five of the directors of public health surveyed felt that they 'always' felt able to influence the priorities of their council in 2015, although this was up from 15 per cent the year before; there was also a drop in their perceived influence over CCGs, 37 per cent saying it had fallen in 2014 and 48 per cent in 2015.

A high proportion of both directors of public health and elected members thought that they could influence decision-making and strategy in and outside councils through the membership of HWBs. However, there was a drop between 2014 and 2015 in those who thought that the HWB was instrumental in identifying the main health and wellbeing priorities for the local area and in their case studies the authors found:

> *…little evidence that HWBs were addressing strategic public health issues, as they tended to focus on issues such as integration and other national policy priorities.*
> (Peckham *et al* 2017)

Finally, the most significant academic study focusing on the role of HWBs as leaders of health improvement was also lukewarm about their impact (Hunter *et al* 2018a). It supports the overall findings above:

> *Many HWBs were yet to position themselves as the key strategic forum for driving the health and wellbeing agenda… HWBs remain a case of 'work in progress' when it came to leadership, collaborative working and integrated service provision. It also suggested that many of the lessons from previous models of partnership working had not informed the working practices of HWBs.*
> (Hunter *et al* 2018a, p 3)

The view from elsewhere

Other assessments of the reforms include an in-depth investigation by Qualitywatch of whether the quality of public health services changed as a result (Davies *et al* 2016), insights from annual Public Health England stakeholder surveys and from inquiries of the Health Select Committee and Public Accounts Committee. Finally, in the run up to the 2015 election, The King's Fund summarised its overall views on the public health reforms. What follows below, focuses on the local government elements of these assessments.

As part of its investigation into public health spending the National Audit Office (National Audit Office 2014) surveyed directors of public health on how they perceived that their local authority spending plans had changed in the first year following the reforms. The results were clear, spending had shifted towards local authority priorities.

Qualitywatch (Davies *et al* 2016) published the first independent assessment of the impact of the public health reforms on quality (defined with reference to access, effectiveness, safety and equity). It assessed trends in 20 key indicators drawn from the public health outcomes framework, a survey of directors of public health and consultants in public health (n=37) and 22 interviews, half with this group and half with service provider and advocacy organisations. The findings on outcomes across key elements of the public health ring-fenced grant are summarised in Table 2 below. From 2009 to 2015, six indicators showed continuous deterioration, 10 continuous improvement and the remainder a combination.

Davies *et al* (2016) were careful to caveat their findings, rightly stating the interpretation of trends in any public health indicator is challenging, and any change is likely to be influenced by the many different factors that will affect health behaviours, including societal factors, system changes and legislative and regulatory changes. They also recognised that the follow-up time to see changes in the indicators was short, given only the final two years of the five-year trend analysed was covered by the reforms themselves.

Nonetheless, those surveyed and interviewed thought that local government procurement was already leading to improved effectiveness, equity and access to services, although re-tendering did place a significant burden on existing and potential providers. Some also thought the switch into local government increased the potential for integration between public health and

other local government functions and services. However, there were concerns about fragmentation in some areas (particularly sexual health services) and a loss of public health input into NHS commissioning. A strong message was the increasing pressure from financial challenges, and that more difficult prioritisation decisions would need to be made in future.

Table 2 Direction of trends in public health indicators from 2009 to 2015

Area of public health	Indicator		Direction of trend
Sexual and reproductive health and HIV	Provision of long-acting reversible contraceptives by GPs		Improving
	Genital warts		Improving
	Late diagnosis for HIV		Improving but may have slowed
	Teenage pregnancy		Improving but may have slowed
	STI rates	Gonorrhoea	Deteriorating
		Syphilis	Deteriorating
		Genital herpes	Deteriorating
		Chlamydia	Deteriorating
Substance misuse	Substance misuse treatment waiting times		Improving
	Completion of substance misuse treatment		Improving but may have slowed
	Alcohol-related hospital admissions		Deteriorating
	Number of people undergoing substance misuse treatment		Stable
Smoking	Smoking in pregnancy		Improving
	Adult smoking prevalence		Improving but may have slowed
	Number of people setting a quit date with NHS stop smoking service		Deteriorating
	Proportion of successful quitters		Stable
Childhood obesity	Obesity at age 4–5		Improving
	Obesity at age 10–11		Stable
Immunisations	MMR immunisation uptake at age 2		Improving but may have slowed
	DTaP/IPV/Hib immunisation uptake at first and second birthday		Stable

Source: Davies *et al* 2016

26

Parliamentary scrutiny – who's accountable for what?

A triumvirate of parliamentary committees – The House of Commons Committee on Communities and Local Government (CLGC), the Public Accounts Committee (PAC) (supported by the NAO) and the Health Select Committee (HSC) – looked at the local authority reforms in the context of wider changes in the early years after the reforms.

The first to do so was the CLGC as part of a broader inquiry into the role of local government in health (House of Commons Communities and Local Government Committee 2013). It welcomed the return of public health to local government given the importance of local government services and decisions for health and saw HWBs as the key forum for those decisions, but there was a clear concern about accountability, which also extended to CCGs.

> *Given the Health and Wellbeing Board's pivotal role in the new local health system, as the forum for local government, the NHS, the public and providers, each Board must be held accountable for its work. But it is unclear whether HWBs will be held responsible for health outcomes in an area. We have heard differing accounts from Communities and Local Government and Health Ministers as to how or, indeed, whether they will be. Accountability clearly cannot take place just through the election of the Board's local councillors, and this seems to be an area of real confusion. The questions are, what are HWBs to be accountable for, given their lack of powers; and, what sort of accountability is appropriate: democratic, procedural or financial? We were concerned also by the suggestion that the Director of Public Health, a member of the Board, would inform the scrutiny committee if the Board were performing poorly. This would place Directors of Public Health in an invidious position, and we therefore do not consider this to be a satisfactory or robust mechanism to hold Boards to account.*

> *We recommend that the Government clarifies the procedures for holding Health and Wellbeing Boards to account, including the role it expects local overview and scrutiny committees to play and the role of the Director of Public Health, given their position as a Board member.* (House of Commons Communities and Local Government Committee 2013, pp 17–8)

The HSC's first significant report focused on the role of Public Health England (House of Commons Health Committee 2014), nonetheless it also had things to say about the local system, particularly unfilled director of public health

posts and the reporting of some to other local authority directors, arguing that the latter would reduce the power of directors of public health to drive public health reform. Its inquiry in 2016 focused on the totality of the public health reforms (House of Commons Health Committee 2016), picking up threads on outcomes, accountability and the mechanisms for improvement and funding from the CLGC inquiry.

> *The Committee found that in some local authorities good progress has been made, with modest positive impact on public health outcomes already being seen, but in others, less headway has been made. The new public health system is designed to be locally driven, and therefore a degree of variation between areas is to be expected. However, the Committee is concerned that robust systems to address unacceptable variation are not yet in place.*

> *The current system of sector-led improvement needs to be more clearly linked to comparable, comprehensible and transparent information on local priorities and performance on public health. Changes to local government funding, especially the removal of ring-fencing of the public health grant, must be managed so as not to further disadvantage areas with high deprivation and poor health outcomes.*
> (House of Commons Health Committee 2016)

This was something that the PAC (House of Commons Committee of Public Accounts 2015) (and the NAO's report supporting it (National Audit Office 2014)) also raised. As Amyas Morse, Comptroller and Auditor General of the National Audit Office, said:

> *There is a difficult balance to be struck between localism and the agency's [Public Health England] responsibility for improving health. The agency's ability to influence and support public health outcomes will be tested further if the grant paid to local authorities were no longer to be ring-fenced.* (National Audit Office 2014)

Summary

There was a lot of scrutiny in the first few years of the reforms. The majority of this came from the reflected views of those in local government, notably directors of public health and other senior local government officers, and on issues of process especially the task of bedding into a new culture, with all its challenges and opportunities. This work was supplemented by in-depth inquiries by parliamentary committees and academic work. As a result of this

work, other issues started to be raised including where accountability lay, the role and effectiveness of HWBs, and how outcomes were changing as a result of the reforms, alongside worries about the level of the grant, and what might happen if the ring-fence was removed.

The King's Fund's verdict on the Coalition government's track record on public health at the time of the 2015 election was consistent with the findings above, both on the major achievement of managing a huge practical and cultural change for the public health system and the challenges that remained.

> *The transfer of public health functions and staff from the NHS to local authorities has gone, in most cases, remarkably smoothly, with directors of public health confident of better health outcomes in the future and reporting positive experiences of working in local authorities. Many directors are also influencing local authority decisions well beyond the confines of their ring-fenced public health budget… However, progress is variable, and in some areas there remains much work to be done to bridge the cultures of the NHS and local authorities, and clear differences in the understanding, value and use of scientific evidence to determine decision-making and* policy… *Public Health England and local authorities appear to be adapting to their new roles well, but more is expected from Public Health England in its challenge function to the rest of government. Good intentions have not yet been translated into outcomes by local authorities*.
> (The King's Fund 2015)

All this sets out the territory on which any longer-term assessment of local government and the public health reforms should be calibrated. However, this also needs to consider the very different context for public health in local government now compared to 2010.

4 Assessing the longer-term impact

This section moves beyond assessing the transitional phase to more substantive issues. How have the reforms effected innovation in public health? Have they led to more integration or fragmentation? What have the impacts on outcomes been? We also set out the significant changes to the financial and policy context against which any judgements need to be calibrated.

The context against which change needs to be judged

The government's response to the 2008 financial crisis was to cut funding across the public sector. In relative terms the NHS received a more generous settlement than most areas of spending including annual real growth, though well below the long-term average and below what is needed to keep up with demand (The King's Fund *et al* 2018). However, local government has taken a big funding hit seeing significant cuts across the many areas that public health teams went to local government to influence. Local authorities have seen a 49 per cent real-terms cut in central government funding between 2010/11 and 2016/17 (Figure 4), leading to a 28.6 per cent reduction in their spending power (National Audit Office 2018). As a result, spending on activities that support public health, such as housing, culture, transport, adult social care and environmental services has fallen. Growth in children's social care spending is a rare exception (*see* Figure 4). The success or otherwise of the public health reforms need to be judged within this funding context.

The funding challenge has been accompanied by the development of policy in both local government and the NHS that complicates judgements about the impact of the reforms. In the local government there has been a continued push towards more devolution, most clearly seen in Greater Manchester, but also reflected in different specific forms across the country. In the NHS, NHS England has pursued the policy of integration through the development of 44 regional sustainability and transformation 'partnerships' (previously 'plans') (STPs) specific programmes such as the vanguards, and now the development and roll-out of integrated care systems (ICSs).

Figure 4 **Change in spend by service area, all local authorities in England, 2010/11 to 2016/17**

Notes
1. Data shown is net current expenditure. However, for adult social care transfers from health care bodies are also included. This includes the element of the Better Care Fund received and used by local authorities.
2. GFRA is the General Fund Revenue Account. This provides revenue funding for the bulk of local authority services and is funded primarily by government grants, business rates and council tax. It is separate to the housing revenue account which is used to maintain local authority housing stock and is funded primarily through rental income.

Source: National Audit Office 2018

Both have arguably acted to shift the locus of power and decision-making to the regional and system level, on the broad local government side devolution from Westminster 'down' to regions, and on the NHS and adult social care, through NHS England's approach to integration, from the local 'up' to STPs and now ICSs. In 2015 we speculated about the potential impact of these developments on the role of HWBs, and on public health (Buck 2015b). As we said then:

> *They are, after all, the bodies who are meant to set the overall health and wellbeing strategies for their areas. In order to tackle inequalities in health effectively, all those who sit on the health and wellbeing board need to align their strategies and actions to this end. But there is little sign that inequalities in health are at the heart of NHS England's new*

> *models of care, or more broadly the focus on integration, or that these models are subservient to local health and wellbeing board strategies.*
> (Buck 2015b, p 7)

Mirroring the move to more devolution on the local government side have been reforms to funding mechanisms. Government policy has been to reduce the contribution of central government grants and increase the contribution of local sources of funding, especially the retention of local business rates. This ongoing process means that the ring-fenced public health grant has gone from being one of the smallest stable sources of central government income for local authorities to one of the largest (Terry *et al* 2017).

Finally, we have also seen the testing of the detail and spirit of the 2012 Health and Social Care Act, and where the boundary between local government and NHS responsibilities lie for prevention. While NHS England has been clear that a 'radical upgrade in prevention' is required (NHS England *et al* 2014), it has also sought to test the boundary of where its own responsibilities lie, most notably with respect to PrEP (pre-exposure prophylaxis: a pill taken pre-sexual activity that is protective of transmission of HIV). NHS England argued that, as a result of the public health reforms, it was local government's responsibility to fund PrEP and the NHS had 'no power' to do so. The National Aids Trust (supported by the LGA) challenged this in the courts, and was successful, the final ruling clarifying that:

> *…NHS England has erred in deciding that it has no power or duty to commission the preventative drugs in issue. In my judgement it has a broad preventative role (including in relation to HIV) and commensurate powers and duties.*
> (Courts and Tribunals Judiciary 2016)

Innovation

Accelerating innovation and, in particular, the adoption and spread of innovative practices in the NHS, has long been an issue (Castle-Clarke *et al* 2017). There are many reasons for this including a hierarchical culture, siloed working and the lack of attention and resources for adoption as opposed to research (Collins 2018). Although there is little academic literature (Walker 2006) local government is often argued to be more innovative, in part due to the permissive legislative environment, as Peckham *et al* (2017) point out, councils have 'the same broad powers as an individual to do anything unless it is prohibited by statute'; and in part due to its very nature, in contrast to the NHS, being a set of local institutions more responsive to the needs of local

citizens and with more autonomy from central decision-makers. Latterly, the challenge of austerity has also given local government further reason, if needed, to innovate to meet the needs of citizens within ever tighter resources.

The transfer of public health responsibilities to local government, and its timing, could therefore have unleashed and created the environment for more innovation. Is there any evidence of this?

In short, there have been no systematic 'before-and-after' studies to prove this one way or the other, partly because public health was so hidden when it was in the NHS. However, there is plenty of case study and other evidence to suggest that local authorities have been very innovative in their new roles. The LGA hosts a searchable innovations database (www.local.gov.uk/case-studies), which, at the time of writing, includes 52 case studies under 'public health' (and more under specific themes such as alcohol, obesity, etc). The LGA worked with NESTA on the Creative Councils programme that includes examples of councils innovating across a wide range of their services (Parker and Leadbetter 2013). The LGA has also supported six councils to work with the Design Council on innovative approaches to public health challenges (The Design Council undated).

However, since the reforms three areas of local authority innovation particularly stand out: innovation in sexual health services; innovation in seeing communities as important co-producers and assets in improving health; and innovation in health and wellbeing services.

Sexual health services

Local government as a sector has innovated in sexual health services, a responsibility that transferred to local government as part of the public health reforms. Sexual health services account for the largest proportion of the public health grant at national level. They are also open access and are therefore an open-ended finance risk for local authorities. The Fund's work on HIV (Baylis *et al* 2017) and sexual health services (Robertson *et al* 2017) demonstrates how local government has innovated in these services. Many services in local areas had not been scrutinised for many years before local government took on responsibilities as commissioning leads for sexual health services. We found many examples of innovation in these services, both in commissioning and services delivered.

Local government sexual health services have seen cuts in spending, particularly for prevention (Robertson 2018), but there has also been a concomitant 13 per cent increase in numbers of tests since 2013/14 (Local Government Association 2019b) indicating more cost-effective commissioning. This has been accompanied by service innovation, particularly the rapid introduction of online testing in London and elsewhere. Overall, local authorities have managed a serious financial situation well through innovative commissioning.

The London HIV Prevention Programme, established in 2014, is an example of cross-borough innovation and collaboration on public health including a major multimedia campaign under the brand 'Do It London' (London Councils undated). It aims to increase the frequency of HIV testing and promote the adoption of safer sexual behaviours, including uptake of PrEP. It has already achieved significant progress against its core objectives. The programme was the result of successful collaboration between public health directors across London, with all boroughs participating until 2017, and all but two boroughs agreeing to commit funding until 2019. However, innovation has not come without problems (*see* 'Integration and fragmentation', p 39).

The relationship with communities

Councils have innovated in their relationships with their communities, in particular seeing the assets for health in communities, not just the needs and deficits. Public Health England has documented this innovation in its work on whole-systems approaches to community-centred public health, setting out how 12 local authorities have innovated to reduce health inequalities (South and Stansfield 2019). While each case study is different there are common elements including: having a shared, long-term vision and narrative for community empowerment and resilience; being informed by community insight; and having local participation infrastructures for joint decision-making with communities. This work has informed Public Health England's recent guidance to support place-based approaches to reduce health inequalities (Public Health England *et al* 2019).

Perhaps the most well-known council in this regard is Wigan (a member of the Creative Councils programme), which won the *Local Government Chronicle* council of the year award 2019 for its work. The King's Fund has recently published a deep-dive narrative exploration of Wigan's work (Naylor and Wellings 2019). To be clear, the council's work started before the public health reforms, but the reforms have helped. It is also no coincidence that

Wigan had an NHS and local authority jointly appointed director of public health before the reforms.

Wigan was one of the first councils to realise that austerity meant salami-slicing budgets would not be sustainable in the long term. But Wigan's approach includes a clear and explicit deal between the council and residents with significant investment in involving people, acting on the things that they say are important (such as green spaces), and training more than 3,000 council staff. At the time of writing, Wigan has 13,000 residents who are 'health champions' (including heart, cancer and alcohol champions, young health champions and dementia friends) in a population of 323,000 people. Naylor and Wellings (2019) set out the full story on Wigan's approach to community, and how the council has also worked with its staff to move to an asset-based approach to health improvement with results that are starting to be seen in health outcomes.

Integrated health and wellbeing services

Finally, councils have also been innovating in how they deliver health and wellbeing services to their residents. There are now many good examples of services that take into account clustering of health behaviours (such as smoking, drinking alcohol at unsafe levels, and poor diet and low physical activity); around 7 in 10 adults have at least two risk factors from this list (Buck and Frosini 2012). Further, having three or four of these risk factors is linked to high premature mortality and is more common in those with lower educational status and in less professional jobs. For people in these groups, who require more behaviour change support, it is also often harder to commit to changing behaviours because they are more likely to have problems with debt, housing and other factors that make lives harder. Simply providing an array of separate services that take no account of clustering or the wider context of people's lives is unlikely to be effective.
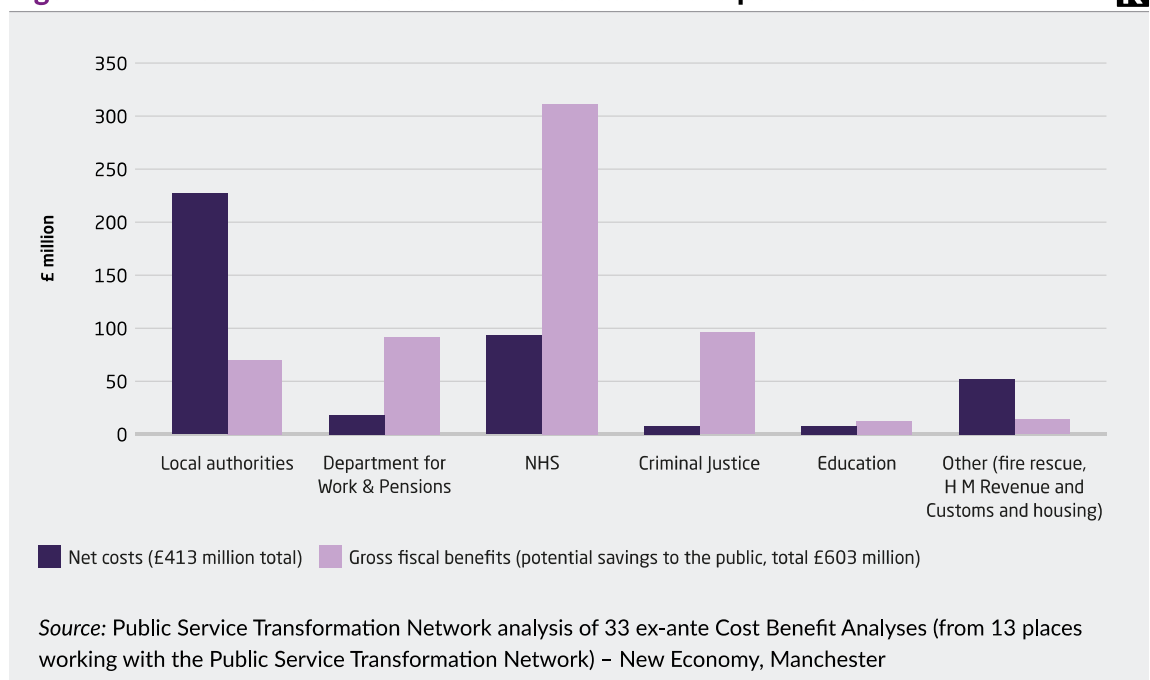
Councils have been innovating and working with residents to understand and respond to their needs by developing more integrated health and wellbeing services. An in-depth case study analysis of a range of these services (Evans and Buck 2018) showed how they were underpinned by extensive market research with residents, with many drawing on the COM-B theoretical behaviour change framework (Michie *et al* 2011) and were innovating with digital channels and delivery methods. Most importantly of all, these services were integrated across behaviours, were based on a deep understanding of needs, and offered wider support ranging from access to housing and debt advice to providing psychological interventions.

In conclusion, despite a lack of a systematic assessment, many councils have innovated in specific areas of public health commissioning and provision, and in developing their engagement with their communities around their health. This innovation is both a symptom of and a response to austerity but is also symptomatic of local government's wider culture and relationship with its citizens.

Incentivising further innovation: a sting in the tale

It is clear that local authorities are good innovators. But there is a sting in the 'tale' in that the evidence shows that much of the fruits of this innovation is realised in payback to the NHS, not local government itself. The National Audit Office assessment of 33 public sector reform projects illustrates this (National Audit Office 2016). While local authorities bear the cost burden of innovation, the gains in demand and cost reduction often flow to others locally, especially the NHS (*see* Figure 5).

Figure 5 **How costs and benefits are shared across the public sector**

Source: Public Service Transformation Network analysis of 33 ex-ante Cost Benefit Analyses (from 13 places working with the Public Service Transformation Network) – New Economy, Manchester

This is, in effect, an 'incentive trap': local government takes the risks in innovating but the pay-offs are seen in the NHS. Until this is addressed, for example, through more use of joint budgets, joint commissioning or agreements on gain-sharing and a truly joint sense of purpose, local authorities will have less incentive to innovate.

Local government public health funding and expenditure

The public health reforms were introduced at a time of relative optimism, particularly on finances. Despite the 2008 financial crisis, it is easy to forget that the public health grant initially increased at a faster rate than CCG funding in the NHS. There was also a significant effort to increase funding to areas where PCTs had historically under-invested in public health, so funding levels were closer to where they should be. Around a third of local authorities received a cash increase of 21 per cent against the estimated baseline over the first two calendar years from 2013/14. At the time when public health reform was 'bedding in', the grant was a source of funding growth for local government.

Despite this good start, a thorough zero-based analysis of how much overall funding was needed for a well-functioning public health system was never undertaken. Instead, the quantum of what could be identified as relevant spend in the NHS was defined as the pot for local government public health functions, and then redistributed. This was a missed opportunity to truly understand how much should be spent on public health, as opposed to basing local authority budgets on what the NHS chose to spend.

In any event, this good start came to an end in 2015/16. First, the budget for this year flat-lined in cash terms (a real cut) at 2014/15 levels, and then in the middle of that year, the government announced an unplanned £200 million (7.6 per cent) mid-year cut as part of austerity measures (Buck 2015a). This, however, was masked in the data by the in-year pre-planned transfer of responsibilities for public health services for children aged 0–5 to local government from the NHS. The overall level of the public health grant therefore increased, even though the like-for-like level of funding fell. Since then the cash and real trajectory has continued downwards as the government announced that the grant would fall by around 3 per cent every year in cash terms to 2020/21 (Buck 2019). The folly of this, and what this has led to in terms of actual local government expenditure, has been well documented both in terms of the overall fall and what has happened to spending on specific services. Figure 6 shows the trajectory of the overall grant. The dark blue bars show this initial growth to 2014-15, this is where the cuts started, and the trajectory since. The lighter blue shows the like-with-like spend (taking out the distortionary effect of the transfer of services for children aged 0-5).

Figure 6 Spending on public health in England 2013/14 to 2019/20

Source: Buck 2019
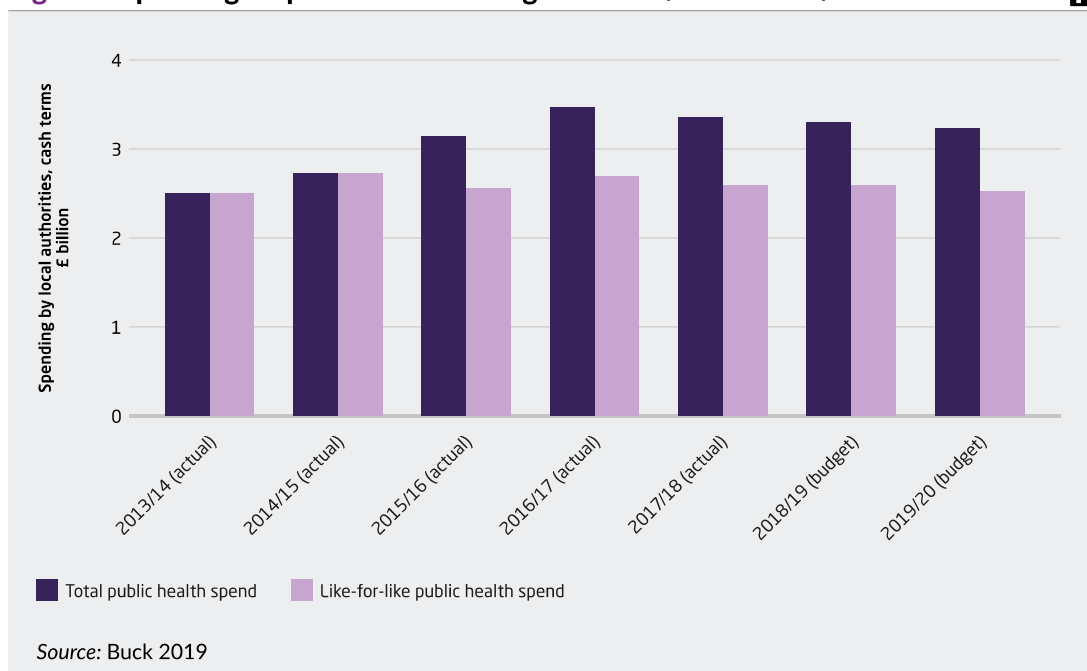
Of course, this does not consider inflation of population growth, so the real cuts in spending power are bigger than this graph suggests. The Health Foundation (Finch *et al* 2018) has looked in depth at the trajectory of the grant and the future of public health spending. Its overall assessment estimates a reduction of almost a quarter in spending per person expected between 2014/15 and 2019/20 (given 2019/20 figures are only plans at the point of writing). The recent announcement of the 2020/21 public health grant suggest an end to the cuts and possibly a 1 per cent real-terms rise, though debates continue about this given possible new burdens that local government will be expected to meet (Bunn 2019).

Whatever the funding outcome for 2020/21, it will not be enough. The Health Foundation and The King's Fund have jointly stated that the grant, which currently amounts to £3.1 billion a year, is now £850 million lower in real-terms than in 2015/16. With population growth factored in, £1 billion will be needed to restore funding to 2015/16 levels (The King's Fund and The Health Foundation 2019).

Integration and fragmentation

The reforms have led to both integration and fragmentation. There are several types of integration to consider. The first is integration within local authorities and their wider functions; the second is the contribution to health and care integration; and finally the integration with regional structures associated with

devolution, such as combined authorities. But, any change to structures and responsibilities also brings risk of fragmentation. There is strong evidence that this has happened in some specific service areas.

Integration within local government

One of the chief arguments for the reforms was that they would bring local decisions about public health closer to the bodies and sectors that had the most influence over the public's health: local government and its functions.

There are some excellent examples of where this has happened. Coventry adopted the principles of the Marmot review (Marmot *et al* 2010) through its HWB strategy, winning the *Local Government Chronicle* Public Health Award for its efforts (*Local Government Chronicle* 2016) and was visited by The Health Select Committee as an exemplar of what a whole-system approach to public health could look like (House of Commons Health Committee 2016, p 77). The LGA's series of annual reports on public health progress document other case study examples (*see,* for example, Local Government Association 2019c). Represented in, but also beyond the published literature, there are areas – for example, Wigan and Coventry, but also others such as Hertfordshire, Blackburn with Darwen, Sheffield and Newcastle – that are highly thought of and well known, in practice, to have integrated public health into local government and be strongly influencing all local government functions.

However, it is hard to paint a full picture from published case studies and well known and highly thought of examples alone. More systematic and representative analysis is also required. Two studies shine light in this respect. The LGA surveyed lead members for public health and chairs of HWBs in 2017, receiving responses from 34 per cent of councils (responses from 45 to 57 responses depending on question), focusing on many aspects of public health and how it was operating within councils. The New Local Government Network (NLGN) surveyed a larger and more diverse sample, including more than 400 local government officers (60 per cent of respondents), directors of public health (12 per cent), elected members (19 per cent) and others (9 per cent) (Terry *et al* 2017). Its focus was specifically on how far public health had influenced the wider council through shaping policy on the wider determinants.

In the LGA survey, a large majority of respondents (82 per cent) thought the council had a clear vision to improve public health. More than three-quarters thought the advice received from the public health team was very helpful, and

almost 60 per cent thought they were very effective in championing public health issues across the council, only a tiny minority thought they were not effective. One indicator of integration across the council is to what extent other directorates understand how they contribute to the public's health. Just over seven in ten respondents either agreed (22 per cent) or tended to agree (49 per cent) that all parts of the council understood the role they played in improving the health of the population.

The NLGN survey went into more detail. The news was good, showing that 88 per cent of non-public health officers agreed that public health had engaged with other departments in their council and 88.7 per cent of elected members agreed that public health had engaged with members in their council. More than 55 per cent of directors of public health who responded had added new services to address the wider determinants of health as a result of the move. However, the news was also nuanced. There has been much greater influence in 'people' services rather than 'place' services (*see* Figure 7). For example, there is high engagement with children's services, adult and children's health and social care, and culture and leisure services. In contrast, there was less engagement with transport, benefits and local economic development. The latter are missed opportunities, given the significant impact of 'inclusive growth' on the public's health and the focus at local and national levels on industrial strategy.

Figure 7 Level of engagement with public health remit, by department

Public health respondents, n=87
Source: Terry *et al* 2017
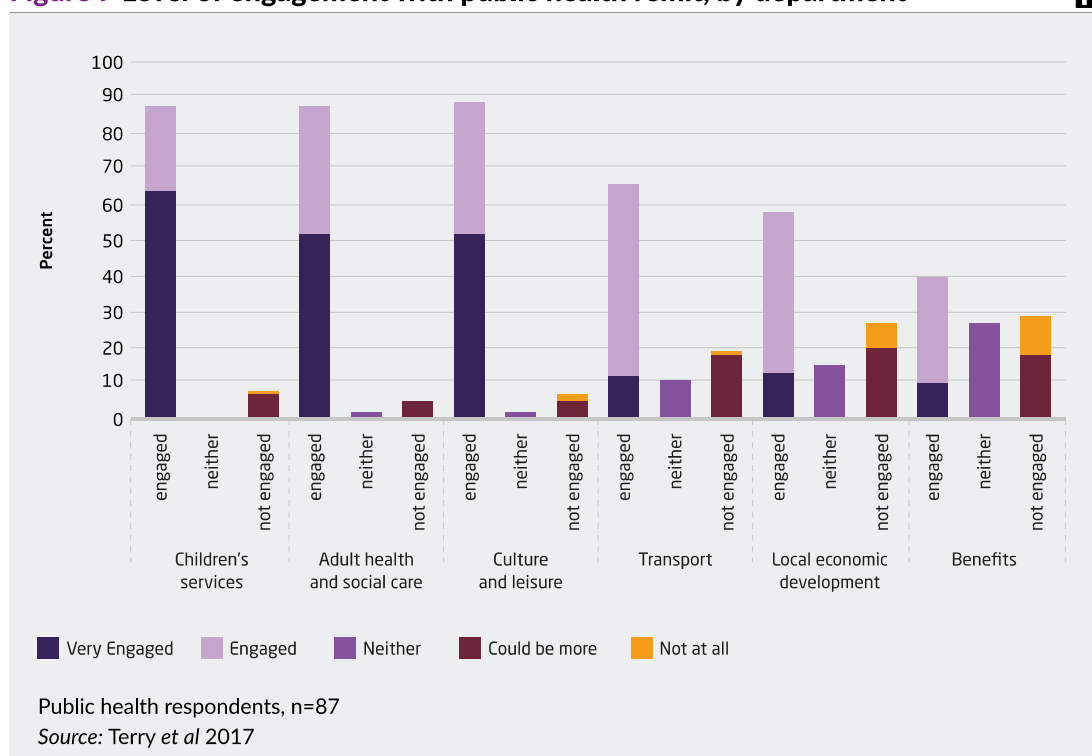
The NLGN also looked at the split between single and two-tier councils and found that district council officers who responded to the survey were less likely to feel engaged by public health and less likely to feel they had been involved in the creation of Joint Strategic Needs Assessments and to have strong relationships with public health teams. This is another lost opportunity given the wide range of areas where district council functions have a big impact on the public's health. Buck and Dunn (2015) argue that district councils are the 'sleeping giants' of public health setting out recommendations for how district councils can have more impact. In some places district councils have been active on health and wellbeing (as the LGA has shown in case studies (Local Government Association and District Councils' Network 2019)) but on the whole it seems their role and potential has been underplayed.

Integration with the NHS

The NLGN report (Terry *et al* 2017) shows that CCGs, primary care and pharmacies are areas of particularly strong external collaboration (alongside the voluntary and community sector). This should not be a surprise, given primary care trusts (PCTs) (the fore-runner of CCGs and planners of primary care) were where public health teams 'came from' before they were in local government and the reforms explicitly gave duties to public health to work with the NHS locally (*The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013*). However, there is a question about how far local government public health teams have been involved in the wider NHS integration agenda, first through STPs and more recently experiments through the vanguards and integrated care systems (ICS).

Overall, it seems clear that STPs have not done well at engaging with public health colleagues in local government or focused as much on areas such as prevention. The King's Fund review of London's STPs (Kershaw *et al* 2018) sums this up.

> *We heard from interviewees that directors of public health have contributed substantially to STPs' prevention agendas. Notwithstanding the fact that some people felt this was positive, we also heard that, for different reasons, more work is required.*

> *Some interviewees suggested that STPs are not the best level for this work, with more scope for progress in individual boroughs, in some cases, building on the work of health and wellbeing boards, and some initiatives being led across London as a whole. Others recognised the*

opportunity associated with STPs but felt that rather than prevention informing their agenda, it had been somewhat siloed to date.

As one interviewee from a national body put it, 'My concern… is that it [prevention] is still not in the DNA of the STP as a whole'.

While there is much expertise across the capital, including in Public Health England, it can be difficult to make best use of this expertise in partnerships like STPs that are still relatively new and have focused much of their work to date on the NHS.

We were also told that work on prevention has tended to be crowded out by a focus on short-term operational issues and that the financial position of local authorities and the NHS has impacted on STPs' ability to invest in prevention despite their best intentions to do so.
(Kershaw *et al* 2018, pp 35–6)

Part of this is likely to be because the majority of England's 44 STPs have been NHS-led; it is no accident that in those few where local authority chief executives have been in the lead there has been a much stronger focus on the wider determinants of health, such as housing, and stronger engagement with local government public health (Buck 2018). It is also because over time, as the quote above implies, the 'S' of STP has been prioritised over the 'T' and finance issues and the need to balance budgets across NHS systems have taken precedence over transformation and, therefore, collaborative, place-based approaches to prevention, where local government public health expertise is critical. The further development and roll-out of ICSs offer an opportunity for stronger integration (Milne 2018), and we return to this in our section on next steps below.

Integration with regional structures

Although the local authority boundary and functions are critical for place-based health, so are wider geographies, particularly combined authority areas. The NLGN (Terry *et al* 2017) found that there was less engagement at this level than expected:

A supportive local policy context to address the wider determinants of health is progressing, but slowly… The opportunity to engage with these issues through combined authorities has also not yet been used to full effect.
(Terry *et al* 2017, p 54)

London and Greater Manchester provide two case studies on how public health expertise has been used at city-region level. Naylor and Buck (2018) assessed how London was performing against criteria developed from an analysis of international cities tackling complex public health issue successfully. They found that the distribution of public health expertise in successful cities closely mirrored where the critical decisions that affect the public's health are taken. For example, in New York and Barcelona many of the decisions affecting public health are made at city level and this is where public health expertise is concentrated (in New York in the Department of Mental Health and Hygiene and in Barcelona in the Agència de Salut Pública de Barcelona with a staff of around 300). In contrast, in London, most powers over public health sit with the 33 boroughs and this is where most public health expertise sits, and that is appropriate. Nonetheless, London has significant city-wide powers that impact on health including control over the transport system and the mayor's statutory health inequalities strategy (Mayor of London 2018).

A clear message from this research was that the limited number of expert public health personnel at city level placed significant constraints on London's capacity to undertake collaborative, city-wide work on population health improvement. While expertise is available in the Greater London Authority (GLA), in Public Health England's London office and specific functional bodies, such as Transport for London, the relevant teams are stretched too thinly to have the influence and impact that they could have and are fragmented across multiple organisations. As Helen Walters, former Head of Health at the GLA, said:

> It's not about bringing in a load of new health laws, it's about influencing the decisions that are being made constantly across city government.
> (Naylor and Buck 2018, p 49)

In London, changes are coming through the newly agreed *Our vision for London* (Healthy London Partnership 2019) which sets out how its signatories (the Mayor, London Councils, NHS London and Public Health England London) intend to work more closely together to make London the world's healthiest global city and the best global city in which to receive health and care services, including making 'the most of the very direct social, economic and environmental roles we each play as major anchor organisations in London' (Healthy London Partnership 2019, p 8). This involves specific commitments across 10 areas from childhood obesity through air quality and violence

reduction to end-of-life care; and steps to better align neighbourhood, borough and regional structures between local government and the NHS in order to strengthen and develop London's population health systems.

However, the most integrated approach between local and regional levels is to be found in Greater Manchester. Even here there is a creative tension between the decisions taken at borough level and those taken at 'Greater Manchester' level. Plans at the Greater Manchester level are intended to complement work on population health being led by the 10 local authorities involved in the regional partnership, for example, the Wigan Deal (*see* p 34). The Greater Manchester Population Health Plan aims to build a single population health system across the 10 localities that make up the Greater Manchester metropolitan region. This includes creating a unified leadership and governance system for population health and a common approach to commissioning. As part of the region's devolution agreement, public health resources previously controlled by NHS England are being delegated to the Greater Manchester Combined Authority, and there is an intention to explore extending public health commissioning at Greater Manchester level where this 'achieves additional impact and is complementary to that at locality level' (Greater Manchester Combined Authority 2017).

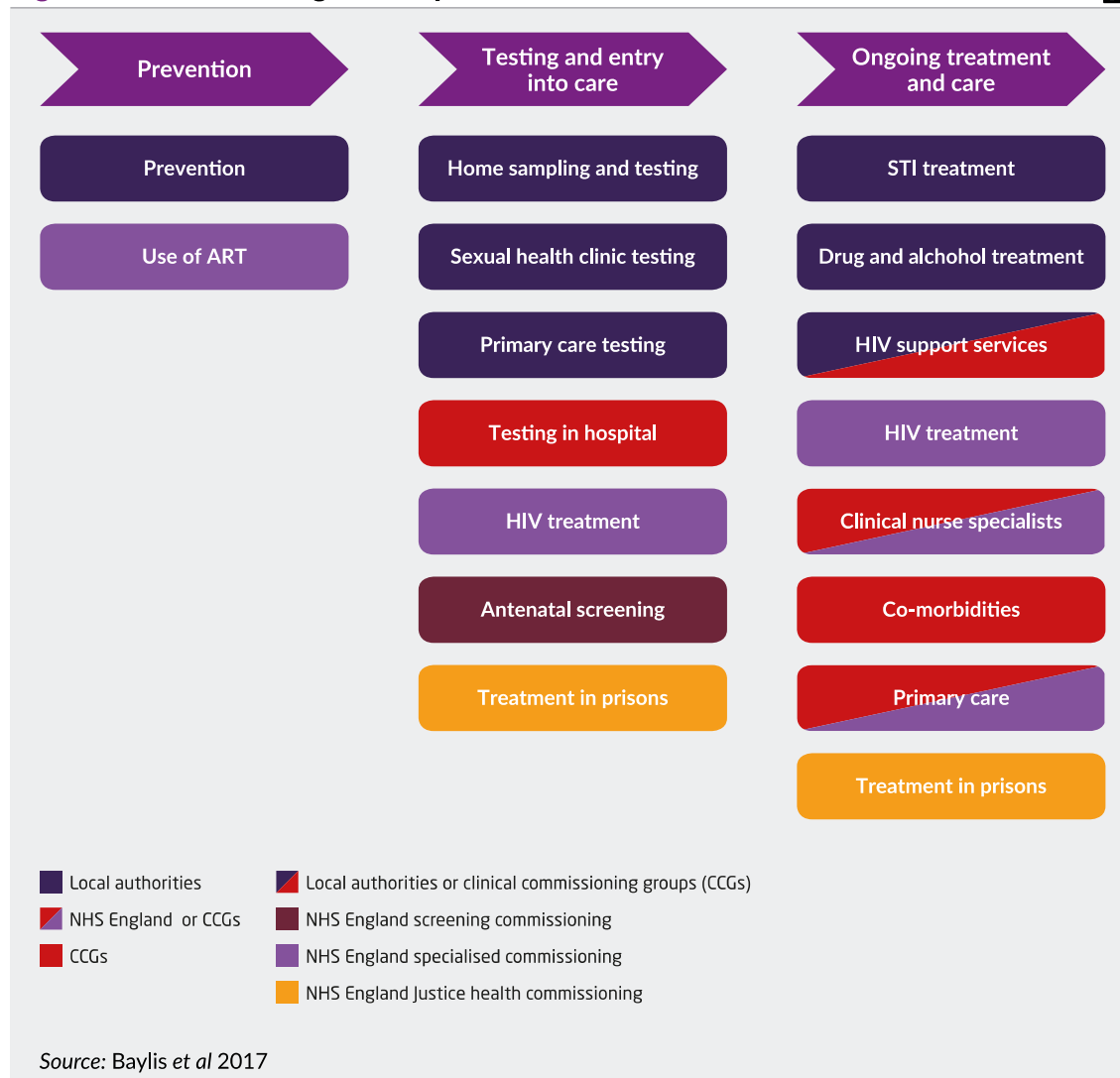### *Fragmentation across NHS and local government pathways of care*

Despite the focus on integration, there is evidence that the reforms have led to fragmentation in some specific areas of care. Unsurprisingly, this is more evident in services where pathways of care now cross more boundaries between the NHS and local government responsibilities, for example, in drug and alcohol services.

However, the area that has been most studied in this respect are sexual health services, including HIV. This is an area where local authorities have clearly innovated (*see* p 33) but this has led to teething problems in the short term. For example, Baylis *et al* (2017) found that in some cases clinics were decommissioned before online services could take up the slack and there were problems with destabilising HIV services when sexual health services were recommissioned.

There is no doubt that the reforms have complicated commissioning along the pathway of care and in the services that patients receive around HIV and sexual health (as was foreseen to some degree in the consultation on the reforms at their inception (Department of Health 2010, p 26). Figure 8 sets

out the commissioning landscape for HIV services through prevention, testing and treatment and the myriad functions and commissioners involved.

Figure 8 Commissioning landscape for HIV services since the 2012 reforms

Prevention	Testing and entry into care	Ongoing treatment and care
Prevention	Home sampling and testing	STI treatment
Use of ART	Sexual health clinic testing	Drug and alchohol treatment
	Primary care testing	HIV support services
	Testing in hospital	HIV treatment
	HIV treatment	Clinical nurse specialists
	Antenatal screening	Co-morbidities
	Treatment in prisons	Primary care
		Treatment in prisons

■ Local authorities   ▨ Local authorities or clinical commissioning groups (CCGs)
▨ NHS England or CCGs   ■ NHS England screening commissioning
■ CCGs   ■ NHS England specialised commissioning
■ NHS England Justice health commissioning

Source: Baylis *et al* 2017

The HSC raised this as a core issue (House of Commons Health and Social Care Committee 2019):

> *A recurring theme in evidence to this inquiry was the complexity caused by fragmentation of both commissioning and provision, as well as the variation in the level of services available to patients. We also heard evidence of the considerable time, energy and money that can be wasted through repeated procurement and tendering processes.*
>
> *Some areas have managed to negotiate their way around the bureaucratic obstacles and work more effectively together. This needs*

to happen everywhere in order to put patients first, and more should be done to make joint working easier.

Witnesses to this inquiry told us that a new, national strategy is needed for sexual health, to help both providers and commissioners to deliver sexual health services to a high quality and consistent level, in the face of the challenge of fragmented structures.
(House of Commons Health and Social Care Committee 2019)

As a result, the HSC recommended a new national strategy, headed by Public Health England, to set out one clear set of national quality standards for commissioners to adhere to, encompassing all aspects of sexual health. However, it did not recommend shifting commissioner responsibilities. Baylis and colleagues (2017) also found that there was little appetite locally for shifting responsibilities and therefore argued for local HIV and sexual health planning to be a shared responsibility across the NHS and local authorities, jointly led by the director of public health and a lead clinician. However, opinions differ, the Institute for Public Policy Research argued for a shift of sexual health commissioning back to the NHS (Darzi *et al* 2018). This debate helps to explain the *NHS long-term plan* commitment that:

…the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be.
(NHS England 2019, p 33)

The review following this statement has now concluded and found that local authorities remain the best place from which to commission the services reviewed. However, it also reinforced the findings above. The NHS and local government need to be better partners and show stronger collective leadership locally around public health commissioning, particularly around sexual health services (Department of Health and Social Care 2019).

Transparency, mechanisms for improvement and accountability

As set out above, one of the key issues parliamentary committees inquiries focused on was clarity around local accountability for public health, and the linked question of mechanisms for improvement. One key element that underpins both is transparency. Before the reforms this was highly opaque,

there was no transparency even on what was being spent on public health, it was hidden in NHS spending.

More transparency

The reforms have led to much more transparency. We can now all see what is happening to local government public health funding and spending (even if we don't like what we can see); citizens can attend and review the papers of important decision-making forums, such as HWBs; and nationally there are sets of data that allow assessment of how well local areas are doing on public health, the public health outcomes framework (Public Health England 2018a) being the most obvious (*see* Figure 9).

Figure 9 The Public Health Outcomes Framework website

Source: Public Health England undated

However, transparency on its own is not enough to ensure improvement. In 2010, the incoming Coalition government abolished the National Indicator Set, the mechanisms behind it (such as Local Area Agreements) and the Audit Commission (whose role was to oversee local government performance). Funding was also cut for the Improvement and Development Agency for local government. This was a significant loss and Public Health England does not have a remit to police what local authorities choose to do, and beyond providing support and tools, intervenes only in ill-defined, exceptional circumstances. Into this gap, the main way that local government seeks to improve is through peer-to-peer improvement.

Sector-led improvement

The LGA has developed a well-respected and valued sector-led improvement (SLI) approach and, with the ADPH, has been clear that sector-led improvement:

> *…is based on the principle that the local government sector is responsible for its own improvement, including managing the risk of underperformance, and takes a collective responsibility towards that*. (Local Government Association and Association of Directors of Public Health 2018, p 17)

To support councils to apply the principle of owning its own performance, the LGA has developed a number of supportive tools. Published case studies show where this approach and these tools have worked well in public health through regional and themed programmes and council 'peer-to-peer challenge'. Such peer challenges are formal and in-depth, involving a scoping exercise, self-assessment and a rigorous challenge visit from a team of professionals, including a chief executive, director of public health, councillor and others, all of whom are from outside the local authority's region. A visit lasts four days overall, on the last of which feedback is given to the HWB and public health team. The results are transparent and published (Local Government Association undated c).

The LGA, in its end-of-year report for 2018/19 (Local Government Association 2019a) demonstrates that all councils are engaged with SLI and the various programmes that the LGA provide. This included training and developing more than 800 councillors and delivering more than 140 peer challenges. More than 95 per cent of leaders and chief executives say that support from the LGA has had a positive impact on their authority.

The LGA recognises that peer challenge can be improved further including developing communities of improvement and finding ways of demonstrating impact. This last is particularly important, and as the LGA itself says:

> *A narrative for public health SLI is needed to explain what it is delivering for chief executives and councillors. Public health SLI needs to position itself in the future local government system, for example as an outcomes assurance mechanism.*
> (Local Government Association and Association of Directors of Public Health 2018, p 18)

But despite its clear benefits is SLI enough for public health? The tools are voluntary, there is self-selection in its use, and some of the tools are highly resource intensive, which asks a lot of those involved. Arguably those that understand that they will benefit from it are the areas that need it least. What is happening in those areas that have not engaged with support for improvement in their public health services and outcomes is perhaps the bigger question. While SLI is clearly valuable and should continue, the concerns of the House of Commons Draft Local Audit Bill ad hoc Committee in 2012 are still relevant:

> *We are concerned that as a result of the draft Bill there a vacuum surrounding Value for Money work for individual local bodies which sector led organisations, including the LGA, are expected to fill. This places a substantial amount of responsibility on the LGA…*
> (House of Commons Draft Local Audit Bill ad hoc Committee 2012, paras 81-2)

It is also much less clear what happens when things go wrong in local government public health (as it was when it was in the NHS), and there is a lack of clarity over how that is actually defined. For example, if a key indicator (perhaps life expectancy) or a suite of PHOF indicators drop consistently and significantly in an area compared to experience in similar areas (in terms of population characteristics) what does this mean, would that be seen as failure, and if so, who's failure? What would be done, if anything? More generally the Public Accounts Committee has been concerned about local authority governance at a time of increasing financial stress (National Audit Office 2019).

In this context, we welcome the new Local Authority Governance and Accountability Framework Review Panel (*Local Government Chronicle* 2019),

which includes representatives from across government and those organisations that play a role in the oversight of the sector. The panel provides an opportunity to assess the effectiveness of the local accountability framework and to make suggestions for its improvement. External auditors also make an assessment of every council's value for money on an annual basis, the Redmond Review is currently consulting on the external audit process (Ministry of Housing, Communities and Local Government 2019).

However, these are questions that have no clear and transparent answer. While the ADPH, with the Department of Health, Public Health England and LGA, helpfully set out how concerns would be escalated about public health performance, as the reforms were being implemented, there was less on what might qualify as a concern or what happens when concerns move to real deterioration (Local Government Association *et al* 2014).

In extremis, Public Health England can step in and there is evidence it has, for example, in Northamptonshire on finances where there were concerns over the public health grant not being used for public health purposes (*Local Government Chronicle* 2018). But it was made very clear at the outset that Public Health England's role is to support local government's public health role, not to hold it to account or performance manage it on finance or on outcomes. It produces a myriad of useful data and tools to fulfil its support function, including prioritisation frameworks to support local decision-making (Public Health England 2018b) which do seem to be helpful locally (Hunter *et al* 2018b).
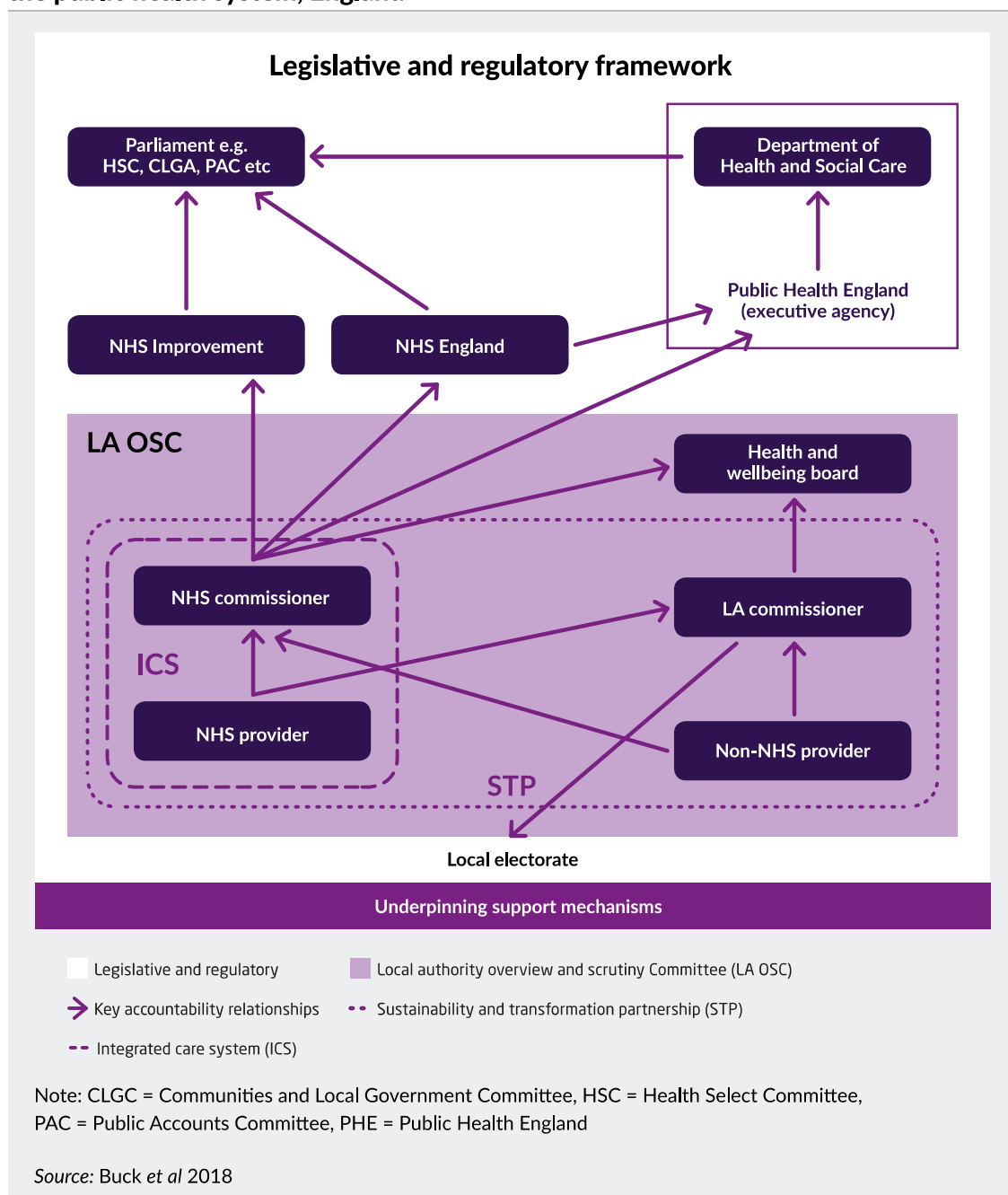
In principle Public Health England therefore has the data and the tools to conduct in-depth comparative analyses of relative performance – good and bad, disseminate this information directly to local government and place these analyses publicly on its website. But it doesn't do this. Relatively recently, common tools used in the NHS such as 'dashboards' have been introduced for a small range of key indicators drawn from the PHOF (Public Health England undated). Public Health England needs to do more to tackle variation (*see* p 64).

Accountability

This leads us back to the vexed question of accountability for public health. This is inherently complex because it depends on co-ordinated action by different sectors and organisations.

Following the Health and Social Care Act 2012, the accountability landscape in and around the public health system has become more complicated and as a result, overall, it is weak and it is not clear where responsibility lies, particularly for 'failure', however defined. Lines and forms of accountability are multiple and complex at national and local levels and between the NHS and local government. Buck *et al* (2018) have attempted to set-out the main lines of accountability visually (*see* Figure 10).

Figure 10 **Key accountability frameworks and relationships in 'and around' the public health system, England**

Note: CLGC = Communities and Local Government Committee, HSC = Health Select Committee, PAC = Public Accounts Committee, PHE = Public Health England

Source: Buck *et al* 2018

Quite rightly, local government prizes the democratic principles on which it is based and argues that, ultimately, local politicians are accountable to the public and will be voted in or out, partly on the performance of local government public health. However, there is a clear need to clarify accountability locally, as this does not fall only on the shoulders of local government in relation to public health. How will important new bodies developing through NHS policy, STPs, ICSs and PCNs, be held to account for wider public health and population health outcomes?

Success or failure? Views from both sides of the fence

The transfer of responsibilities from the NHS to local government was not just a technical event, it was also a human one. It involved much stress and uncertainty for staff moving from one culture and way of doing things to another, and the loss of a significant number of directors of public health (*see* p 17). What do directors of public health now think about the long-term implications of that change?

The ADPH 'five years on' survey (Association of Directors of Public Health 2018) summarised views as below.

> *Broadly, DsPH are supportive of the transition to local authorities and feel they can provide robust system leadership from within the local authority setting. However, they feel that the substantial cuts to the public health budget have had a detrimental effect and that transition had weekend the relationship between public health and the NHS.* (Association of Directors of Public Health 2018, p 1)

Of the 56 directors of public health (drawn from 152 local authorities) who responded almost 8 in 10 were positive or very positive about the reforms, reasons for being so included:

- they are better situated to influence the social determinants of health and work more effectively with the local community

- the reforms have enabled more effective working with the local community

- they are better able to provide system leadership.

As one respondent said:

> *Two years before the transition I was genuinely unsure. Five years after I'm definitely sure it's absolutely the right place to be, organisationally speaking.*
> (Association of Directors of Public Health 2018, p 2)

However, more than 8 in 10 respondents thought cuts in public health budgets had had an adverse effect on outcomes, and around 6 in 10 that their relationship with the NHS had weakened. These findings are supported by a recent in-depth interview-based assessment of the reforms in 14 county council areas with directors of public health and others, including senior officers in the NHS, carried out by Shared Intelligence (Shared Intelligence 2019). However, NHS-based interviewees were much less positive than those in local government. Shared Intelligence suggests this is due to five factors:

- fragmentation of commissioning for some key services (*see* p 44)

- the implications of cuts in local government public health budgets for the NHS, particularly providers of those services

- scepticism on whether there are real impacts on the wider determinants of health and related changes in health outcomes

- a lack of status in local government

- too much distance, described by an accountable officer: 'Public health has become remote, not in touch with the reality of primary care' (Shared Intelligence 2019, p18).

This last point is accepted by some in local government, but is seen as a price worth paying:

> *We have good relations with the NHS. The traction of public health within the NHS may not be as strong as it was, but the move away from a medically driven model of public health was an important move.*
> (Local authority chief executive, Shared Intelligence 2019, p 19)

What's happened to outcomes? The acid test

One of the useful outcomes of the Coalition government's reforms was the introduction of outcomes frameworks, including the PHOF. These sent a signal to the system that what mattered most was not what organisations did, or the number of doctors or nurses, but the health and wider outcomes that the NHS, local government and others could influence. Over time, in the NHS and,

arguably, social care, the outcomes frameworks have been overshadowed by a continuing focus on waiting times, workforce and the mechanics of how the system works and there has been less focus on the overall health outcomes achieved from the NHS. The PHOF on the other hand has 'stuck'. It provides constantly updated, refined and live data on key public health indicators across all of England's local authorities and is widely used and referred to locally. Public Health England has also provided tools to help local areas understand, report on and benchmark their position against others including the England average, near and statistical neighbours. Public Health England's stakeholder reviews consistently show that local authorities value and use its tools for needs analysis, and strategy and policy development (Public Health England 2019).

It is therefore disappointing how little Public Health England appears to have used this data to track, analyse and publicise the overall and relative performance of local areas to changing population health outcomes. It has been left to external academics, commentators and scrutiny to attempt to assess the impact of the reforms on outcomes.

The case for poorer outcomes derives mainly from tracking changes in specific local government commissioned services, implications of the funding cuts set out above and examples of poor patient experience. Sexual health services have come under scrutiny, given the existence of strong charities in this sector and parliamentary inquiries and scrutiny. More recently, there has been some specific analyses of other areas, for example, childhood obesity (Liu *et al* 2019).

The case for better outcomes has come mainly from the LGA, through case studies of good practice and successful innovation. The LGA has also argued that under pressure areas such as sexual health services have seen increases in numbers seen while budgets have been falling, inferring that this is a sign of the greater efficiency of services since the transfer to local government.

In the LGA's most recent survey of lead members for public health and HWB chairs (Local Government Association 2018), the vast majority (92 per cent) said that the council has delivered better public health outcomes for its population, but also that funding cuts were impacting on outcomes (83 per cent). The LGA has also looked at the trajectory of some of the major indicators in the PHOF (Local Government Association 2019b). Although a mixed picture, as it states, in the past six years of the 164 indicators in the PHOF, 80 per cent have either been level or improving, and in 2017/18 101

indicators either improved or showed no significant change, which is 76.5 per cent of indicators that can be tested for improvement. (*see* Table 3).

Table 3 Change in public health indicators, year to 2017/18

	Overarching indicators	Wider determinants	Health improvement	Health Protection	Healthcare public health and premature mortality	Total
Improved since previous year	3	12	22	5	8	50
No significant change since previous year	11	7	16	4	13	51
Worsened since previous year	0	5	7	12	7	31
Not possible to compare	2	5	14	3	1	25
Not possible to judge if an increase/decrease is an improvement	0	6	1	0	0	7
Total	**16**	**35**	**60**	**24**	**29**	**164**
Number that have improved or stayed the same	14	19	38	9	21	101
Total where improvement can be compared	14	24	45	21	28	132
Percentage that have improved or stayed the same	100%	79.2%	84.4%	42.9%	75%	76.5%

Source: Local Government Association 2019a, based on analysis of Public Health England, Public Health Outcomes Framework Fingertips data

They summarise some of the main findings.

- Childhood obesity, in children aged 4–5 obesity has been stable, between 9 and 10 per cent, while in those aged 10–11 it is at around 20 per cent. Around 95 per cent of eligible children are measured through the local government commissioned National Child Measurement Programme.

- Smoking prevalence in adults fell from 19.3 per cent to 14.9 per cent between 2012 and 2017, meaning there were 1 million fewer smokers in 2017 than in 2014.

- Despite spending falling, local government-commissioned sexual health services showed attendances in 2017 up by 13 per cent at sexual health clinics since 2013 and the number of tests increased by 18 per cent.

However, not all has been rosy. Childhood obesity has not fallen (with some notable exceptions, for example, in Leeds (Rudolf *et al* 2019) (although there remains debate on the veracity of this (Milne 2019))) and inequalities in childhood obesity continue to widen across all England regions, with the exception of London which already has the highest level of inequality of all English regions (Bann *et al* 2018). The government argues that smoking accounts for around half the difference in life expectancy between the richest and poorest in society yet in England, the gap in smoking prevalence between those in routine and manual occupations and those in other occupations has widened, significantly, since 2012 (Office for National Statistics 2019).

However, whether they are good or bad, setting out trends in outcomes alone does not tell us anything about whether a council's actions were behind them. There are long-term secular trends in many of these outcomes that are continuing. As a result, attributing changes in outcomes to public health reforms requires deeper analysis, either at local level, or statistically at national level. There has been a dearth of this type of analysis until very recently. The first in-depth attempt has been an econometric study from the Centre for Health Economics (Martin *et el* 2019). This seeks to assess the impact of public health grant expenditure on mortality and on the number of quality-adjusted life-years (QALYs - a measure of quality of life) compared to NHS expenditure across all English local authorities. The study found that local government public health expenditure was significantly correlated with reductions in mortality, more strongly so than NHS expenditure. The overall conclusions are that expenditure on the services in the public health grant are likely to be three to four times as cost effective as if that same expenditure had been spent in the NHS baseline. The authors argue that their findings are consistent with other work looking at the return on investment to public health spending (Masters *et al* 2017; Owen *et al* 2012).

An overall opinion

There is not enough evidence to be unequivocal about the impact of the local government public health reforms on overall health outcomes. The case against tends to be based on what has happened to specific services in specific places and therefore does not tell us enough about the big picture; the case for tends to be based on case studies of good practice. The overall assessment by the LGA is useful but is not proof on its own; and does not adjust for other factors that could be driving trends. The Centre for Health Economics work (Martin *et al* 2019) perhaps comes closest to an overall assessment, but it uses relatively crude measures of outcome and a long chain of assumptions, plausible though each may be, in coming to its estimate. It also has no counterfactual, i.e. if these services and functions had stayed in the NHS would the results have been the same? What the study does show, however, is to support the wider evidence that wherever these services and functions sit they are, in the round, a cost-effective use of society's resources and it is economically illiterate for central government to cut the resources to local government to deliver them.

So, the judgement on outcomes must be an informed opinion. In our view the transfer is likely to have improved outcomes overall, through innovation, and through a stronger connection and influence over the local policies and decision-makers that affect the population's health. But this change has collided with huge cuts in local government budgets and it is difficult to disentangle the effects of these from the effects of the reforms.

5 Into the future

Six years in to the public health reforms, local government's financial position is perilous with some local authority leaders predicting the end of all but essential services in the near future (New Local Government Network 2018), national politics has been dominated by Brexit, but compared to 2012 the direction of travel for NHS policy is clearer.

This section sets out what this context may mean for the future of public health in local government. It also sets out a personal view on issues that will shape the future of public health in local government and commissioning, resources and funding, a stronger focus on outcomes and on personal and institutional leadership, including leading through others.

The NHS long-term plan and wider reform

The *NHS long-term plan* (NHS England 2019) provides clarity for the NHS, and by extension its partners. While formulating the plan led to the government looking again at where public health functions sit, its decision to keep them in local government hopefully puts an end to this debate. While there are of course differing views on the long-term plan, it does set the policy environment for the NHS for the foreseeable future. It is therefore important that local government public health is engaged with it and influences its implementation.

The NHS long-term plan and key areas of relevance to local government

The long-term plan is not short on ideas, there are many specific – often disease or condition-focused – commitments within it. But the big picture for local government is what it says on population health, prevention and health inequalities.

On population health

- ICSs are identified as the main tool for delivering population health, they will be required 'to implement integral services that prevent avoidable hospitalisations and tackle the wider determinants of mental and physical ill-health'.

- Population health management will be rolled out in 2019 to support the planning of services and improved population health, to help predict and intervene for those at risk of adverse health outcomes and inequalities. There are really welcome signs that NHS England sees population health management as an important way to facilitate closer working with local government on understanding and intervening in the wider drivers of population health (Brown 2019; White 2019).

- Financial systems will be reformed to move towards population-based funding, to support more preventive and anticipatory care.

On prevention

- By 2023/24 all smokers admitted to hospital will be offered NHS-funded tobacco treatment services (plus a new smoke-free pregnancy pathway and smoking cessation offer for specialist mental health users and in learning disability services).

- The quarter 'worst affected' hospitals will receive alcohol care teams funded from CCGs' health inequalities funds.

- There will be scaling up of existing primary and secondary prevention programmes including: a doubling of places on the existing Diabetes Prevention Programme; weight management programmes in primary care for those with diabetes, hypertension or a BMI>30; a range of clinical commitments to increase earlier diagnosis and screening of cancer; and improved case-finding and follow-up with preventive treatment following NHS Healthchecks.

On health inequalities

- It commits to setting new 'specific, measurable goals' for narrowing health inequalities.

- Resource allocation will be reviewed with the aim of making it 'more sensitive' to areas with higher inequalities and unmet needs.

- There are goals for specific groups. For example, greater continuity of midwife care for women from BAME backgrounds and deprived groups; by 2023/24 380,000 people with severe mental health problems will receive physical health checks; £30 million spent on NHS support for rough-sleepers; and NHS mental health support teams in schools and colleges.

These initiatives are welcome, but the key question is how all this dovetails with local authority public health roles and how to make the most of the long-term plan in terms of population health.

What drives population health is much broader than integrated care. Buck *et al* (2018) argue that the NHS needs to be more aware of its wider role especially in the overlap between the four main pillars of population health: the wider determinants; people's health behaviours; an integrated health and care system; and the communities we live in, and with. The plan says much less about this than it needs to, including next to nothing about the role of the NHS working with communities to improve population health (as opposed to the delivery of community services, and personal responsibility). It is not clear how ICSs will dovetail and work with HWBs; the plan says that, 'ICSs and Health and Wellbeing Boards will also work closely together' (NHS England 2019, p 30) but there is no detail on what this means and there is potential for confusion and duplication.

The plan is also almost silent on the prevention of multi-morbidity, very disappointing, given multi-morbidity is a core feature of inequalities in health – the poorest parts of our communities develop multi-morbidity and all its consequences 10 to 15 years earlier than the wealthiest (Barnett *et al* 2012). Addressing this relies on the connections between the NHS and other critical sectors, for example, housing. Existing services often led by local government public health commissioners have been developing to take this into account. The danger that needs to be averted in the long-term plan is that a well-meaning focus on developing services around individual behaviours and conditions will move the system back to a panoply of siloed prevention and treatment services. How population health management develops will be important in either hastening or preventing this drift.

Finally and worryingly, the plan makes no mention of the store of learning from previous attempts by the NHS and local government to tackle inequalities in health around the Labour government's targets, which we now know were successful (Barr *et al* 2017). Public Health England's (with the ADPH and LGA) recent launch of tools and support similar to that which operated in support of those targets is therefore very welcome (Public Health England *et al* 2019). It is therefore important that NHS England works closely with Public Health England, the ADPH and LGA to ensure that the long-term plan and how it is implemented is consistent and utilises the tools and support provided.

In summary, the NHS long-term plan will need the support of local government to maximise its potential. This will require patience, leadership – both personal and institutional – and an ability to connect NHS initiatives to existing services, policies and approaches locally.

The government's consultation on Advancing our health: prevention in the 2020s

The government published its planned Green Paper on prevention (now a consultation) (Cabinet Office and Department of Health and Social Care 2019) at the end of Theresa May's premiership. It contains some movement on existing issues such as childhood obesity – the main one banning sales of energy drinks to children under 16 (on which the government has been consulting for some time) and setting out further intent – for example re-announced steps towards a smoke-free society and re-announcing the creation of a health index to rival GDP in government decision-making. There are lots of other announcements across a range of areas, each interesting and valuable in and of themselves. But taken as a whole it is not at all clear how they will meet the avowed goal of the Ageing Society Grand Challenge that is to, 'ensure that people can enjoy at least 5 extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest' (Cabinet Office and Department of Health and Social Care 2019, p 10).

In particular, it offers little to local areas and none of the five things that we suggested would help local government (Buck 2019): stronger guidance on the use of supporting legislation to shift towards more preventive systems; clearer accountability and governance for prevention; committing to setting targets for place-based preventive spending as a proportion of total spending; the acceleration of integrated health and wellbeing services that support people's behaviour change but critically recognise that for many people, this requires support with wider problems and issues in their lives; and finally a greater focus on communities and their contribution to health. There was a partial exception on the latter, with a positive mention of the 'Wigan Deal' (Naylor and Wellings 2019) as an example of local government strongly engaging with its communities on health. The decision on the public health grant and whether it will switch to business rate funding has been kicked down the road, again.

Although the consultation paper should have been more local government focused, some policy announcements will be helpful locally, and it will require public health teams to help ensure that aims and goals are translated and

make sense in the local context. We look forward to the government's next steps following the consultation, planned for spring 2020.

Commissioning

The local public service landscape in which the public health reforms sit is complicated and complex. Even understanding and engaging with the NHS and its constantly evolving structures and three letter acronyms from STPs to ICSs, PCTs to CCGs and now PCNs is a non-trivial task. This is before the wider array of structures and committees within local government itself are contended with, let alone those beyond local government and the NHS. This creates boundaries to be traversed.

It is therefore not surprising that one of the things the reforms have led to is more fragmentation in commissioning for some services, particularly in areas of care like sexual health and drug and alcohol services. The government was right to leave these services with local government but also right to call for a strengthening and more collaboration in commissioning and the use of pooled budgets between local government and NHS commissioners for them. Public health teams should be at the heart of how this is resolved.

Resources and resource allocation

There is no escaping the fact that a great shadow hangs over the public health reforms. Local authority budgets have been slashed, which makes it hard to disentangle the effects of reforms from the wider funding position of councils; and explains why some feel that public health would be 'safer' in the NHS. This cannot be allowed to continue, especially given the work of the Centre for Health Economics (and others) that shows that spending on local government public health functions is likely to be four times as cost effective in improving health as spending the same money in the NHS baselines. As a bare minimum, the public health grant should be restored to the same purchasing power as at its highpoint in early 2015/16, this implies an extra £1 billion per annum from 2020/21 (The King's Fund and The Health Foundation 2019). The recent announcement of up to an extra 1 per cent real growth in 2020/21 (Bunn 2019) is welcome, but nowhere near enough to achieve this.

Beyond this, this case needs to be strengthened for the 'right' amount of spending. Doing this is not straightforward and there are several techniques available from international benchmarking against comparators to costing up how much a high-quality portfolio of services would cost to more technical approaches, for example, expanding the budget until it becomes only as cost

effective as NICE's value for money benchmark (given the Centre for Health Economic's analysis this implies a considerable expansion is justified). The Health Foundation have taken another approach estimating that an extra £3.2 billion per year could be required to reverse existing cuts and to move every local authority to its target level of funding calculated by the government's independent advisers, the Advisory Committee on Resource Allocation (Finch *et al* 2018).

But it is not just about how much is available, but how that is raised and allocated. The public health grant itself remains under threat, the recent consultation paper still provides no certainty with the government remaining committed to switching the source of funding for local government public health more strongly to local business rates as part of wider policy; alongside reforms to other funding formulas. The King's Fund view (Buck 2016) is that such a switch, unless very carefully designed, brings high risks especially in those areas that are less able to attract new businesses. These areas are the very ones that are likely to face the greatest challenges to public health. The recent report from the (House of Commons Housing, Communities and Local Government Committee 2018) recommended that the public health grant should not be replaced by business rates but rather the revenue from the 75 per cent retention proposal should be seen as additional to the grant.

Getting better at making a difference to health outcomes

Measuring the attributable health outcome of public health activity at local level is hard. However, this should be essential, not a nice to have. The reforms to the public health system are now embedded and despite all the pressures discussed above, it is legitimate to start asking deeper questions about outcomes.

There is no single right way to do this. On the one hand, we know that local government public health teams work in complex local systems where doing 'x' is unlikely to lead to outcome 'y' in a simple way. We therefore need to understand how these systems work as a whole to understand how outcomes can be improved. But we also have far more comparative data than we've ever had before, on inputs (spending, workforce etc.); outputs (services and activity delivered); and outcomes (health and other valued social outcomes). We need to use this data better to help understand why some areas do better than others, despite having similar populations and similar systems. And finally, local government is innovating all the time but much of this is not

captured, shared or adopted as it could be. Researchers and practitioners need to be better partners in improvement than they are. Below we discuss some ideas on how to move forward.

Rutter *et al* (2017) called for a complex systems model of public health evidence that better reflects this. This is especially true when many public health teams' roles are now about influencing other policies implemented across local government and place. The UK Prevention Research Partnership (Wellcome Trust 2019) has taken up this challenge supporting long-term systems research on the drivers of population health in cities across the UK; and most recently The Health Foundation and LGA have joined forces to offer research support to five local areas tackling complex public health problems through multiple interventions and policies (Local Government Association undated d) Both initiatives should pay-back in helping local areas learn about improving health outcomes in complex systems.

While complex systems are a reality, this does not mean that we should not be interested in or find it impossible to learn from existing data on how health outcomes differ between local authorities and why. Public Health England should be doing more to help this happen, with the support of the LGA. It collects and holds, or has access to, data, on spending and on health outcomes, through PHOF and other sources. We now have more data on comparative performance than we have ever had before but that is not being used intelligently enough.

The Health Select Committee was concerned about this (House of Commons Health Committee 2016), and while accepting that it was entirely appropriate for public health priorities to be different in different areas, argued that there needs to be a 'benchmarking framework that allows for informed comparison and challenge' and that Public Health England should 'publish an annual report drawing together and analyzing local progress towards agreed plans'. In our view the PHOF provides a good framework, what is missing is the underpinning analysis of it, Public Health England needs to step up on helping define, understand and learn from inappropriate variation in health outcomes across the public health system. Three areas that could be commissioned, or undertaken in-house and published, for example, are:

- a review of how local authorities (and their NHS and wider partners) are implementing the Public Health England menu of preventive interventions (Public Health England 2016) and NICE's menu of cost-effective public health interventions (Owen *et al* 2018)

- a relative efficiency analysis of how local government public health funding and activity translate into PHOF outcomes, across the 152 local authorities, disseminated to support local improvement. This could also make use of the rich and publically available data the LGA provides through the LG Inform website on its activities and finances

- a retrospective assessment of the impact on health outcomes of the 'natural experiment' in the first two years of the reforms, when around a third of local authorities received a cash increase of 20 per cent compared to the equivalent PCT baselines.

Each of these would provide very useful information and learning for local authorities and their partners. Finally, we need to learn more from specific public health service development, alongside the impacts of complex systems and looking at variation across local authorities. The LGA's case studies are extremely useful for improving practice. However, many case studies do not go the final step to evaluating outcomes. This may be for many reasons, complexity as set out above, costs or lack of access to research expertise. Therefore, there needs to be more of the following:

- real-time evaluation of innovative services, for example integrated health and wellbeing services (as Evans and Buck (2018) have called for)

- local government should work closely with NIHR to ensure that academic research is more applicable to service development and local public health prioritisation (Lockwood and Walters 2018)

- use of tools such as the NIHR's 'phindr' portal that connects academic expertise with real-world issues and problems that need addressing and evaluating in local government public health (National Institute for Health Research undated).

Towards population health systems

However much funding the receives NHS, it will not be enough to shift the dial on our population health outcomes, from an average performer internationally, to being on a par with the best in the world. The evidence shows that this will require renewed efforts on the four pillars of population health; shifting the resource balance between them; and critically, paying far more attention to the connections between the pillars. (Buck *et al* 2018).

The reality of what lies within the pillars is complex and different in different places. The wider determinants of health can be unpacked into a vast range of drivers of health and policies and practice that affect them from our housing, to the air we breathe, how streets are designed and economic planning and development to name but a few, each of these interacts with the other pillars of population health. Population health systems are now a core part of the policy agenda in the NHS and local government and public health teams need to be at the heart of it.

Personal and institutional leadership

Moving towards local population health systems requires personal and institutional leadership. The public health reforms have strengthened local government's ability to do this, as directors of public health and their teams have learned to operate in local government, and local government has experienced the knowledge and expertise in their public health teams. But this also depends on personal and organisational leadership.

Personal leadership

Directors of public health are in an excellent position to be at the heart of future population health systems. They have the knowledge, understanding and relationships to bring together the four key pillars of population health in local areas. The skills expected of directors of public health as set out by the ADPH, are precisely those skills that are required in the place-based population health systems that are emerging. It is worth setting them out here (Association of Directors of Public Health 2016).

- System leadership – across organisational boundaries working strategically in a complex system with a wide range of stakeholders to influence and facilitate system-wide change.

- Population advocacy – involving advocating and lobbying on 'upstream' issues that affect public health.

- Independence – allowing public health leaders to challenge policy-makers at a national level, to say things that are 'uncomfortable' and to address poor performance at a local level.

- Community engagement – consulting and working with communities using asset-based approaches to co-produce local solutions to public health problems.

- Visibility – building relationships with key partners in health, social care and third sector agencies to influence their agendas effectively and building and maintaining the profile of public health at all levels.

- Making the case for public health – making an effective case for increased priority and resources for the public's health.

- Understanding, interpreting and communicating evidence to ensure that organisations that distribute resources for public health and public health interventions do this in an effective and cost-effective manner.

- Building partnerships – to help lead a whole-system approach across the public sector.

- Looking forward – beyond current pressures to understand future challenges and opportunities to do things better.

- People and management skills – including team building, networking, building trust, negotiation and facilitation skills.

In an increasing number of places, the role of directors of public health and their teams is to maximise the effectiveness of spending the whole local authority budget for health, not just to manage the public health grant. In other areas, they have been key players in changing the way that the council thinks about its role in improving health and delivering care through maximising assets in communities. But as the NLGN shows in its work (Terry *et al* 2017), this is not as common as it could, or should, be. There is also an opportunity to engage with ICSs and PCNs in the NHS, particularly on inequality reduction. The raison d'etre for integration in legislation is (alongside quality improvement) inequality reduction and secondary prevention – much of which is delivered through primary care – is the fastest way to reduce inequalities in life expectancy in the short term. Public health teams can be at the forefront of helping to make this happen, using new tools such as the Place-Based Approaches to Reducing Health Inequalities toolkit (Public Health England *et al* 2019).

Yet, a clear sense from this review of the reforms – shared by those in the NHS and in local government – is that there is now a larger distance between public health teams and the NHS. Part of this is having more resources directly for public health (in the NHS and in local government) to help bridge that gap, and that means people as well as money. But it also requires public health leaders to give power, knowledge and influence away; to lever it in others, be that in local government, the NHS or in the community itself;

essentially to do much more to identify, nurture and support others to lead for population health across their systems in future.

Institutional leadership

Where the institutional leadership for population health comes from must depend on the local context. It could take various forms: a combination of clinical and public health leadership, especially in complex conditions such as HIV (Baylis *et al* 2017) through leadership of STPs and ICSs, the convening and soft power of local mayors, developing new relationships with communities or joint commitments across institutions to an over-arching programme, such as the 'Marmot Cities' approach (Buck *et al* 2018, p 52).

Leadership will also need to reach down to neighbourhoods, and out to other regional structures. In theory, the institutional form that seems to be in the right place to do this is HWBs. They could, and in many areas should, be the place where the local vision for population health – supported strongly by directors of public health and their team – is defined and led from. They are intimately local, given their representation, democratic and can link to other important structures at regional level.

However, despite some clear exceptions (*see* Local Government Association (2019d) for examples) the evidence from this review is that, to date, health and wellbeing boards have not delivered on their full potential to date. There are many reasons for this. However, a recent analysis (Shared Intelligence 2019) concluded that the HWBs most likely to succeed can be characterized by familiar themes: a focus on place; committed leadership with influence across the council and the NHS; collaborations including with STPs; a geography that 'works' (eg, co-terminosity with healthcare structures); and a Director of Public Health 'that gets it'.

So, while HWBs face challenges, there are also immense opportunities. After strong initial support from the Department of Health (as it was then), the world around HWBs changed and changed again; now the momentum for place-based population health systems is evident. HWBs can have a key role at the heart of these, but to take this opportunity they will need to have a focus on place; committed leadership that is able to influence across the council and into the NHS (including working with ICSs and PCNs – Humphries (2019) has set out lessons from early engagement between HWBs and ICSs); and a Director of Public Health and surrounding team with the characteristics set out above. There are encouraging signs that some HWBs are taking this opportunity (Local Government Association 2019d).

6 Conclusion

As the then Chief Executive of the NHS, David Nicholson, said, the health reforms of the Coalition government were so large that 'they could be seen from space' (Ham *et al* 2015, p 10). He was referring to reforms to the NHS, but as importantly – if more quietly – significant changes were happening in local government, with the transfer of responsibility, powers and resources for critical public health services. This was accompanied by the transfer of staff and getting used to operating in a very different culture. It is to the credit of all involved that this has gone so smoothly with relatively little disruption. But there was more: a cultural change, both for public health staff and for councils.

This report has set out a high-level assessment of the reforms and what has happened since. It has drawn on existing material and the insight from parliamentary committees, particularly in the early period of the reforms. More recently, several pieces of in-depth qualitative work have shed light on how the public health reforms have played out: the areas of success and the challenges that remain.

The overall story is one of a successful transition, and an increasing penetration of public health into the work of local government, beyond being commissioners of public health services through the public health grant. But the journey is not complete. As research shows in some important areas, such as economic development and planning, directors of public health have been less successful in influencing decisions than in other 'people' based services. There are also concerns about the fragmentation of some services and a distancing from the NHS. We now need to see a renewed focus on measuring and being held to account for outcomes, not just the delivery of services. But overall, public health services are working well in local government and this is where they can have the biggest influence and impact on the key decisions that affect the population's health.

Local government has been subject to severe funding cuts both to the public health grant and in wider services that have an impact on people's health. We now know that funding through the grant is four times as cost effective in creating health as baseline NHS funding. Funding must be restored by at least

£1 billion per annum to put public health in local government on a stronger footing.

Despite the funding challenge, the opportunities from, and in, local government for public health are huge. They range from supporting communities to take more control over their own health, developing and influencing the whole of local government's functions for health, and the design and implementation of place-based population health systems as they take root. This requires a breadth of knowledge, influencing and relationship skills and the ability to work through others, across communities, organisations and sectors. Fortunately, these strengths and skills – and the ability to seed them with others – lie at the heart of what it is to be a modern public health professional.

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