Response to the consultation on the Public Health White Paper 'Healthy Lives, Healthy People'

The Coalition Government's White Paper 'Healthy Lives, Healthy People' sets out a radical change in the way public health is structured and delivered in England. Under the proposals, the Director of Public Health and most public health specialists will move from Primary Care Trusts (PCTs) to local authorities. Health and Wellbeing Boards will be established to oversee the health and social care services for each local authority area. Other public health functions, such as health protection, will be amalgamated into a new dedicated national organisation Public Health England, which will be part of the Department of Health (Department of Health, 2010a).

The Nuffield Trust welcomes the prominence given to public health by the Coalition Government, including the focus on tackling the wider determinants of ill-health and inequalities at a local level and providing a ring-fenced budget for health improvement. The Trust also welcomes the emphasis on the 'life course' approach as recommended in the Marmot Review. By recognising the impact of different stages and transitions in people's lives within the context of wider social factors, public health action can be more effective (Marmot, 2010). We also welcome the commitment to developing a firm evidence base to inform public health interventions.

The White Paper lays out a challenging agenda and some elements are likely to have a major effect on the future delivery of public health services. We suggest a number of areas where the proposals could be strengthened.

Consultation response

31 March 2011

Transferring public health to local authorities and a new focus for public health

In 1974 much of the public health function was moved into the NHS. Up to this point it had occupied a central role within local government. The shift was prompted by the decision to bring hospital and community services closer together. This brought with it a realisation that a population perspective would be needed in the planning and management of health services (Rivett, 2011). However during the last decade in particular, interest in the contribution that local authorities can make to public health has revived. The Local Government Act 2000 empowered local authorities to promote the economic, social and environmental well-being of an area. Joint working with the NHS was encouraged when the Local Government and Public Involvement in Health Act 2007 placed a duty on PCTs and upper-tier local authorities to produce a Joint Strategic Needs Assessment (Department of Health, 2007). Many Directors of Public Health now hold joint appointments across the NHS and local government. However, whilst joint working has developed, it should be noted that no systematic analysis of the effectiveness of these arrangements has been conducted and many teams remain inside PCTs (Hunter, 2008).

The Nuffield Trust recognises that moving public health into local authorities has the potential to enable local government to influence further the wider determinants of health, both directly through community based interventions and indirectly by ensuring local policy and practice in areas such as housing, transport, education and planning improves population health and reduces health inequalities. But there are salutary lessons to be learnt from when the public health function moved from local authorities to the NHS in 1974. It is widely felt that public health lost its focus, power and influence (Berridge and others, 2006). As with the broader changes to the NHS, the move from PCTs to local authorities needs to be carefully managed to maintain effective public health services (Smith and Charlesworth, 2011).

We are concerned that the current financial context in local government will constrain their ability to deliver improvements in health outcomes. While £1bn of the health budget is ring-fenced for local government to provide 'public health', the latter can encompass the delivery of many services. It is not clear how funds intended to improve public health will be used, and how local authorities will be held to account for this expenditure. The financial pressures faced by local government are significant, with the most deprived local authorities having cuts of up to 8.9% in the 2011/12 financial year (Curtis, 2010).

The consultation suggests that accountability for expenditure should follow the funds, therefore responsibility for expenditure from the ring-fenced grant will rest with Public Health England (Department of Health, 2010b). However, accountability structures are not well-defined and should not only be upwards to Public Health England, but also through the local Health and Wellbeing Board. This could be formalised to ensure elected representatives, Health Watch England and GP commissioners can scrutinise this element of NHS expenditure with respect to the key priorities set out in the joint strategic needs assessment (JSNA).

- **Robust accounting rules must be specified to ensure that ring-fenced public health budgets are protected for use on public health initiatives and not diverted to pay for core services delivered by local authorities which do not have a significant benefit for public health. Accountability for**

expenditure needs to be carefully defined, and reporting mechanisms to Public Health England and the Health and Wellbeing Boards clarified.

- **Evidence suggests that the transition into local authorities and the creation of Public Health England will be a time of considerable risk for maintaining service delivery, quality and strategic direction. This process needs to be very closely managed to mitigate these risks and key priorities identified.**

Rewarding progress with a health premium

The White Paper proposes that a health premium be paid to local authorities in addition to their ring-fenced public health budgets to reward progress against parts of the proposed public health outcomes framework. The health premium will incentivise action to reduce health inequalities, whilst also incentivising health improvements that are spread across the local authority's population (Department of Health, 2010a).

Pay for performance has been used in the NHS before. It was introduced into British general practice through the Quality and Outcomes Framework in 2004. There is some evidence that pay for performance initially improved clinical indicators (Campbell and others, 2007) although evidence as to the overall effect of QOF on health outcomes is inconclusive (Steel and others, 2010) (Dixon A, 2010) (Serumaga and others, 2011).

Setting fair thresholds for these premiums will be difficult and there is a danger that the system may provide rewards to communities where the impact of public health interventions are greater due to inherent population characteristics, rather than because the public health activities were especially effective. Programmes aimed at the most disadvantaged groups can fail to reach their target audience, as an early evaluation of Sure Start demonstrated (Besley and others, 2006). Many of the best performing 'spearhead' PCTs served relatively less deprived populations (Health Committee, 2009).

We suggest a careful approach in developing the methodology for the health premium and piloting of the formula developed to ensure the issues raised in the commissioning consultation paper, such as the sensitivity of indicators to public health interventions and the influence of factors unconnected with public health interventions are properly taken into account.

- **There is a risk that the proposed health premium will increase inequalities if the most disadvantaged areas fail to attract the premium. The government should ensure that the health premium is fit for purpose, tested prior to implementation, and evaluated afterwards with public reporting of the results.**

Supporting NHS commissioning at the local level

A population focus will be essential if GP consortia are to commission services that provide the greatest health benefit to the local population. Yet research into GP fundholding and primary care led commissioning generally has concluded that limited attention was paid to the role of public health (Smith and Goodwin, 2006).

A big risk that will arise from the shift in commissioning responsibility to GP consortia and public health delivery to local authorities is that public health skills to inform

commissioning process and indeed NHS providers will be much reduced. Public health specialists have played an important role in undertaking needs assessments for services, providing and interpreting health data, promoting good analytical methods, marshalling evidence of cost effectiveness of care and demonstrating and challenging variations in clinical performance.

Under the proposals, the Director of Public Health will be, among other things, responsible for advising and supporting GP commissioners. But they will be at a distance from GP consortia (being located in a local authority), GP commissioners generally do not understand the contribution of public health, and there is a risk that local authorities may not fund adequate numbers of public health staff. The White Paper states that Public Health England and the NHS Commissioning Board will work together to support consortia in maximising their impact on improving population health. However, is it not clear what, if any support will be offered at a local level.

The big risk is that a significant section of the public health workforce − those who are skilled in analysis into the quality and cost effectiveness of health services − will be lost, relative to the public health workforce focusing on wider health improvement (in local authorities) or health protection (Public Health England). This would run counter to the strategy set by Sir Donald Acheson in his landmark report 'Public Health in England' which has guided the development of public health and training since 1991 (Acheson, 1988).

If the local public health skills are to be located outside the NHS, then it may be necessary to formalise arrangements for the provision of public health expertise to commissioners. Public Health support for GP consortia could be located within the PCT clusters during the transition. Another solution is for consortia to bring public health specialists in house, and/or encourage the development of a market for public health advice comprised of a variety of providers (akin to commissioning support agencies). This might include local authorities, consultancies or independent specialists. The evidence suggests that if done well, external support can add value to commissioning (Naylor and Goodwin, 2010). However, commissioners' ability to buy in support will depend on the amount allocated to consortia for management, and thus may be constrained.

- **The extent of the provision of public health expertise to commissioning consortia that will be provided by the DPH and Public Health England needs to be clarified. Consortia should be advised as to the benefits of seeking qualified public health expertise − either in-house or through external procurement.**
- **The National Commissioning Board will need to collect evidence that consortia have taken and acted upon appropriate public health expertise such as aligning commissioning to population needs, taking into account inequalities in commissioning services, using the best evidence to inform interventions and identifying health service and treatment priorities.**

Supporting NHS commissioning at the national level

The National Commissioning Board will have a significant role in the proposed new NHS structure. The White Paper states that officials at Public Health England will be expected to work closely with the national leadership of the NHS, presumably the NHS

Commissioning Board. However clauses 1-5 of the Health and Social Care Bill are silent on the roles, routes and accountabilities for the public health input into national commissioning. We believe to would be helpful to clarify how these functions will work together, and what expertise in Public Health England will be available at which level (i.e. national, regional and local).

- **The public health involvement in the commissioning functions of the National Commissioning Board requires clarification in terms of roles, responsibilities and accountabilities to ensure commissioning is based on population needs assessment and a firm evidence base.**

Public Health commissioning of primary care services

The White Paper states that primary care services such as immunisation and screening will be funded by Public Health England and commissioned by the NHS Commissioning Board, thereby centralising the commissioning of these services. However, the population coverage of services such as screening and immunisation varies widely across the country and is influenced by multiple local factors such as the composition of the local population, the quality of primary care, population mobility and the priorities of local commissioners. Currently PCTs hold primary care contracts at a local level and have the flexibility to introduce locally enhanced services. Under the proposed arrangements, Directors of Public Health, located in local authorities will not have analogous levers to develop primary care services as they relate to public health or performance manage them. This is despite the fact that 15% of QOF funds will be related to public health outcomes. Clarity will be needed on how primary care performance will be managed during, and after the transition. We recommend that if primary care contracting is devolved to a regional level that the NHS Commissioning Board should consider mechanisms for local coordination with public health teams.

- **The local accountability arrangements for aspects of public health provided in primary care (such as vaccination) need to be reviewed. Rather than making consortia and general practices accountable for these services to the National Commissioning Board, we suggest exploring devolution to a more local level.**

Influencing and improving NHS services

The new arrangements proposed in the White Paper allow for partnership work between the health service, social services, other local authority functions and the voluntary sector. However, multiple organisational boundaries and their likely lack of co-terminosity may make it harder for commissioning decisions to be made for local communities. Furthermore, not only local authorities will be commissioning public health, but also the GP consortia, the National Commissioning Board and Public Health England.

Local Health and Wellbeing Boards will have an important role in ensuring that the services commissioned meet the needs of the local population. However, the levers at the disposal of these Boards have yet to be made explicit; the latest guidance aimed at GP consortia refer only to their duties to consult and contain no advice for how disagreements between a Health and Wellbeing Board and a consortium might be dealt with (the White Paper proposes that if such disagreement is unresolved locally, a letter can be written to the National Commissioning Board, which will have extensive powers

to direct GP consortia). But it is difficult to see how this process will be workable in all but the most exceptional cases (Department of Health, 2011b).

The Department of Health could look at more locally based solutions to promote cooperation, including devolving performance management for contracts held by the NHS Commissioning Board and Public Health England to a more local level, formal terms of reference, governance arrangements and agreements for managing conflict. The duty of partners to work together could be strengthened further; currently local authorities and consortia only have to have 'regard to' the most recent assessment of needs and strategy (Department of Health, 2011a).

- **The duty to take into account local needs should be strengthened in legislation as the Health and Wellbeing Boards are the central linchpin in bringing together local health and social care planning and commissioning.**
- **Workable arrangements for arbitrating locally when there are unresolvable conflicts between the Health and Wellbeing Board and the GP Consortia need to be developed.**

Measuring success with outcomes

The White Paper's ambition for having shared target outcomes is helpful and will enable local partners to work towards shared goals with aligned incentives. However, we note that under the proposed arrangements, the NHS will in fact share remarkably few indicators with public health.

The shared indicators focus mainly on the prevention of premature mortality. There is a risk that the health service will focus predominantly on improving treatment for those already diagnosed. Yet many public health interventions, such as screening and brief interventions in primary care, occur in the clinical setting. We suggest that the outcomes frameworks are developed to ensure that the number of improvement areas/indicators that are shared between the NHS and public health are increased and reflect the important role of the NHS in primary as well as secondary prevention. For example, two indicators suggested for Domain 4 of the public health framework, screening uptake and incidence of low-birth weight of term babies are heavily influenced by action in the health service (Department of Health, 2010c). It is not clear what the QOF indicators for public health will be, however it will be essential that these are also aligned with the public health outcomes framework.

- **Shared indicators should be developed for the NHS and Public Health service to ensure that incentives are aligned. This should ensure that consortia and the wider NHS remain focused on preventing ill health.**

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