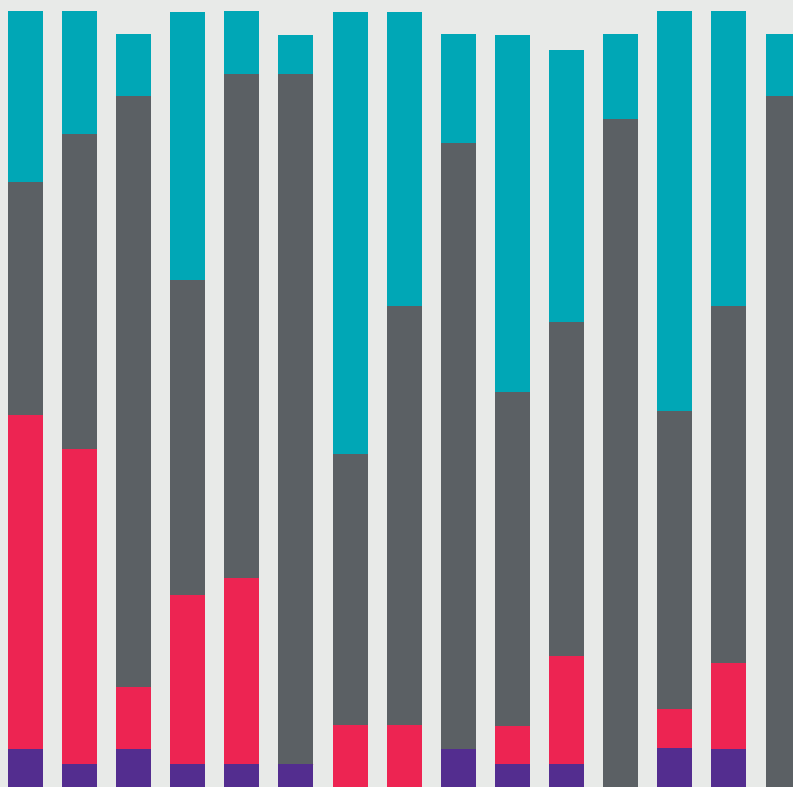


## Focus on: Public health and prevention

Has the quality of services changed over recent years?

### Research summary




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# About QualityWatch

QualityWatch is a major research programme providing independent scrutiny into how the quality of health and social care is changing. Developed in partnership by the Nuffield Trust and the Health Foundation, the programme provides in-depth analysis of key topics and tracks an extensive range of quality indicators. It aims to provide an independent picture of the quality of care, and is designed to help those working in health and social care to identify priority areas for improvement. The programme is primarily focused on the NHS and social care in England, but also draws on evidence from other UK and international health systems.

 The QualityWatch website [www.qualitywatch.org.uk](http://www.qualitywatch.org.uk) presents key indicators by area of quality and sector of care, together with analysis of the data. This free online resource also provides research reports, interactive charts and expert commentary.

## About this report

QualityWatch Focus On reports are regular, in-depth analyses of key topics. These studies exploit new and innovative methodologies to provide a fresh view of quality in specific aspects of health and social care. This QualityWatch Focus On provides an overview of public health outcomes in recent years and considers the opportunities and challenges presented as efforts are made to maintain the quality of services in the light of recent reforms and financial pressures. This research summary provides an overview of the key findings from the report. The full report can be accessed at [www.qualitywatch.org.uk/public-health](http://www.qualitywatch.org.uk/public-health).

## Acknowledgements

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## Introduction and background

**Against a backdrop of substantial changes to the way public health services in England are commissioned and increasing funding constraints on local government, this QualityWatch report provides an overview of public health outcomes in recent years. The report also considers the opportunities and challenges presented as efforts are made to maintain the quality of services in the light of these recent reforms and financial pressures.**

The top three causes of premature death in the UK – heart disease, lung cancer and stroke – place a significant burden on the NHS, social care and society more generally, yet they are all preventable (Department of Health, 2010). Many behaviours that contribute towards these (and other) conditions are also preventable, including smoking, excessive alcohol consumption, lack of physical exercise and obesity.

Investing to improve the population's health makes economic sense. In the UK, annually, treating people who are overweight or obese costs the NHS £5.1 billion, smoking costs 3.3 billion, alcohol costs £3.3 billion and physical inactivity costs £0.9 billion (2006/7 figures)<sup>1</sup> (Scarborough and others, 2011). Interventions to prevent unhealthy behaviours are cost-effective (Van Gils and others, 2011; Owen and others, 2012), yet only about 4% of the NHS budget in England is spent on prevention (Butterfield and others, 2009).

In April 2013, the system in England for supporting public health and wellbeing underwent significant reorganisation following the implementation of the Health and Social Care Act 2012 (H&SCA 2012) (HM Government, 2012a). The H&SCA 2012 established NHS England, an executive, non-departmental public body of the Department of Health, and local clinical commissioning groups (CCGs) to commission local NHS services.

At a national level, various public health organisations were brought together in April 2013 under Public Health England (HM Government, 2012b; Department of Health, 2011). At a local level, local authorities (LAs) became responsible for improving the health of their population, led by directors of public health (DsPH). In discharging these new responsibilities, LAs were to be supported by ring-fenced public health budgets and a new statutory duty to “take such steps as it considers appropriate for improving the health of the people in its area” (HM Government, 2012a). The H&SCA 2012 also created new statutory health and wellbeing boards within each upper-tier LA in order to agree an integrated way to improve local health and wellbeing (HM Government, 2012c). Responsibilities for commissioning or providing public health services were transferred from the Secretary of State to local government or delegated to NHS England (Department of Health and NHS England, 2015) (Table 1).

A commitment to prevention and public health also formed a key cornerstone of the vision for the NHS outlined in the Five Year Forward View (NHS England, 2014; Public Health England, 2014a):

**“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.” (NHS England, 2014)**

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<sup>1</sup> Throughout this summary, all years given in relation to data use the date format from the original source in order that statements remain accurate. In the majority of cases, these will be fiscal years (e.g. '2006/7'), but in some cases years given are calendar years (e.g. '2006') since this is how the original data were presented.

**Table 1: Summarised list of public health services/functions and the body responsible for their delivery following implementation of the Health and Social Care Act 2012**

| Transferred to local government   | Remained within the NHS  |
|---|--|
| Child Measurement Programme*  | Child Health Information Systems   |
| Prescribed children's (0–5 years) services <sup>†</sup>   | Cancer screening programmes  |
| Children's (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 (drug and alcohol services)  |  |
| Local authority role in health protection*  |  |

\*Prescribed functions. †Came into effect on 1 October 2015 – includes universal health visiting services and targeted support (e.g. Family Nurse Partnership).  
Source: HM Government (2013).  
This list is abbreviated. For a full list see appendices at [www.qualitywatch.org.uk/public-health](http://www.qualitywatch.org.uk/public-health)

But the challenges of meeting this evident commitment to public health need to be understood within the context of recent cuts to funding across health and local government. These cuts add to pressure to address the immediate consequences of ill health, potentially at the expense of investment in services that prevent ill health in the longer term. The 2015/16 LA public health budget was cut by 7% (£200 million) (Department of Health, 2015a), and will be followed by a 3.9% cut annually over the next five years – equating to a real-terms reduction of £600 million by 2020/21 (HM Treasury, 2015; Nuffield Trust and others, 2015). Furthermore, recent analysis by the Nuffield Trust, the Health Foundation and The King's Fund shows that the £15 billion of Department of Health spending that lies outside of NHS England – and which includes around £0.7 billion of Public Health England expenditure, in addition to around £3 billion in public health grants to LAs – will be cut by a real-terms 21% between 2015–16 and 2020–21 (or 4.5% average cut a year) (Nuffield Trust and others, 2015).

This report provides an initial overview of the changes to public health outcomes over recent years, and considers the opportunities and challenges presented as efforts are made to maintain the quality of public health services in the light of recent system reform and funding pressures.

## Approach

This report provides a summary of changes in key public health indicators, supported by qualitative evidence from professionals closely involved with the delivery of public health services.

We examined trends and regional differences in 20 indicators of quality across five areas of public health (sexual and reproductive health and HIV; substance misuse; smoking; childhood obesity; and immunisations). The research uses nationally available indicators from the Public Health Outcomes Frameworks and other validated sources to examine changes in public health indicators in England between 2009 and 2014, and regional variation in trends. A full list of these indicators is available in the appendix document.

In order to provide a more nuanced view of the current picture in England, we carried out an online survey among directors of public health (DsPH). The survey response rate among DsPH was 28% (34/120). There were three additional unexpected responses from public health consultants, which made a total of 37 responses from senior public health professionals. The aim of the survey was to deepen our understanding of how recent system reforms and funding pressures have affected the quality of public health services and functions. This survey was also used to identify topic areas to explore in more detail using quantitative analysis. This information was supplemented by interviews with 11 DsPH and 11 individuals from other service provider and advocacy organisations for public health in order to triangulate findings between the local views and national data.

It is important to note that the numbers of individuals surveyed and interviewed was small, so the views expressed are not necessarily generalisable or representative of all those working in these areas across England. However, the reflections do provide valuable context and highlight important issues that would not have been evident from examination of the population-level indicators alone.

## Findings from analysis of indicators

### Public health measures do not show dramatic change over recent years

Interpreting trends in indicators for public health is challenging, since any change is likely to be a consequence of many different factors, including poor health behaviours, societal influences, and legislative and regulatory changes affecting service provision. The H&SCA 2012 was implemented in April 2013. It is likely to take time for any organisational changes and funding cuts to have a clearly discernible impact on outcomes at a population level, so continued oversight of indicators for public health is important. By bringing together indicators across five key public health topics, this report provides a baseline for future comparisons.

From 2009 to 2015, 10 indicators showed continued improvement. In five of these, there was some evidence that progress had slowed, but it is too early to tell whether this reflects a true change in these indicators. Six indicators showed continued deterioration, four of which were within sexual and reproductive health and HIV. The trend was stable for the remaining four indicators (Table 2).

We highlight key findings within the five topic areas identified as areas of concern in the survey: sexual and reproductive health and HIV; substance misuse; smoking; childhood obesity; and immunisations. For more information on the importance of these topic areas, recent changes to service commissioning and provision, and additional analysis and interpretation of the indicators, please see the full report.

**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                        |               |

## 1. Sexual and reproductive health and HIV

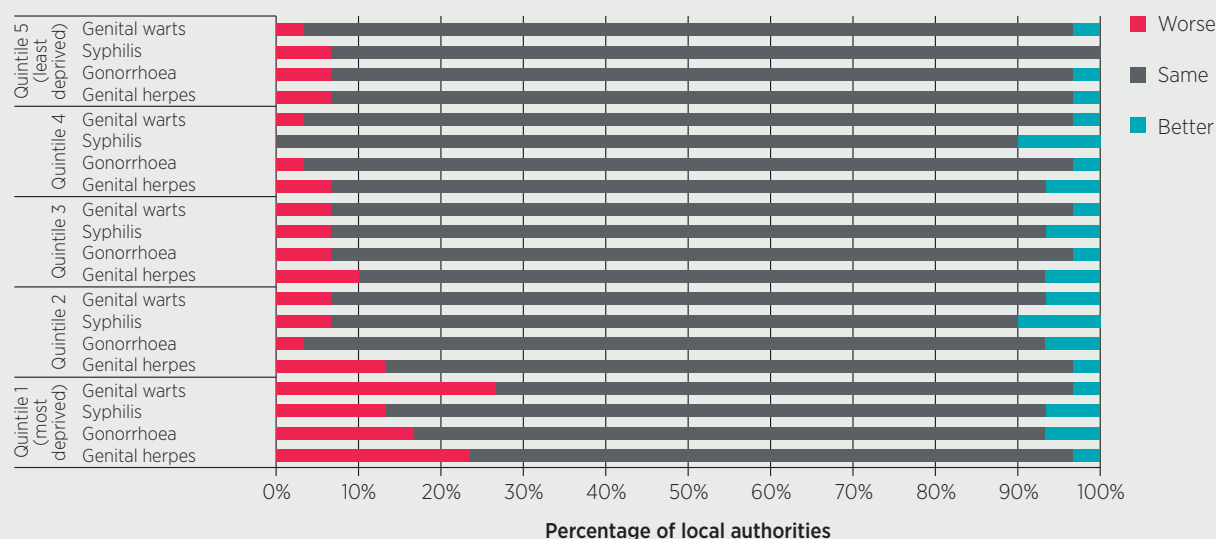
### Improving access to contraception, but increasing rates of STIs

It is widely recognised that a local government approach offers greater opportunity to think more broadly about sexual health and to deliver an integrated approach across local partners (Public Health England, 2014b; Local Government Association and others, 2013; British Association of Sexual Health and HIV and the Faculty of Sexual and Reproductive Healthcare, 2012; Local Government Association, 2013a; Wilkinson, 2015; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015). But there are concerns that commissioning arrangements and service provision has become more fragmented following the H&SCA 2012, and that reduced funding will have a detrimental impact on maintaining access to high-quality care (British Association of Sexual Health and HIV and the Faculty of Sexual and Reproductive Healthcare, 2012; Wilkinson, 2015; White, 2016; All Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015; Faculty of Sexual and Reproductive Healthcare, 2014).

**Across the eight indicators tracking sexual and reproductive health and HIV, we draw attention to the following findings:**

- Ensuring women of all ages have access to the full range of contraception and can obtain their chosen method quickly and easily can prevent unplanned pregnancies (Department of Health, 2013). **The provision of long-acting reversible contraceptives (LARCs), a more effective method of contraception, increased in sexual health services** (22.6% increase over the period 2009/10 to 2013/14) and in primary care (9.3% increase from 2011 to 2014). An examination of regional trends found that primary care provision of LARCs had deteriorated significantly compared to what would be expected (based on the national trend) in 15% (23/150) of LAs, and may reflect a reduction in funding for LARCs in primary care reported in some areas (Primary Care Women's Health Forum, 2014).
- Since the Teenage Pregnancy Strategy for England in 1999 (Department for Education, 2010) there have been marked declines in teenage pregnancy in England, yet it still has one of the highest teenage pregnancy rates in Europe (Office for National Statistics, 2014). From 2009 to 2014, **the teenage pregnancy rate decreased** by 38.5%, from 37.1 to 22.8 per 1,000 women aged 15–17 years. The decrease in teenage pregnancy was significantly better than what would be expected based on the national trend in 10 LAs, and worse than expected in three LAs. Encouragingly, a larger percentage of LAs showing improvement were in more deprived areas, reflecting greater improvements in areas with higher need.
- From 2009 to 2014 **there were large increases in the rates of gonorrhoea (109.8%), syphilis (46.9%), genital herpes (12.2%) and chlamydia (8.9%)** (chlamydia data from 2012 to 2014 only). LAs in more deprived areas had larger increases in these rates than would be expected based on the national trend (Figure 1). If these increases reflect a real change in STI rates, this is extremely concerning. However, the trends may be attributable to more routine testing and case finding in sexual and reproductive health services as well as increased unsafe sexual behaviour.
- The **downward trend in the percentage of new HIV diagnoses diagnosed late** in England (from 52% in 2009 to 40% in 2014) is promising. However, the decline in new diagnoses slowed over 2013 and 2014. Continued targeted messaging to encourage testing among high-risk groups (Public Health England, 2015a) is needed to ensure this slowing does not continue.

**Figure 1: Percentage of local authorities by deprivation quintile and STI that had significantly better, the same or worse outcomes compared to expected, based on the England trend, from 2009 to 2014**



## 2. Substance misuse

### Improved waiting times and treatment completion for some substances, but increasing alcohol-related admissions to hospital

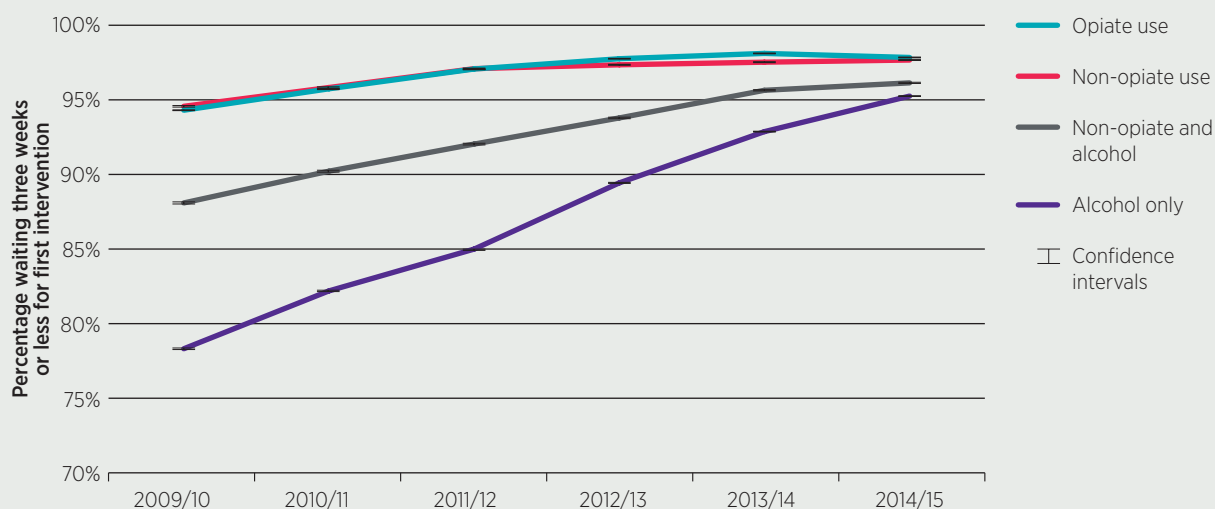
In April 2013, following implementation of the H&SCA 2012, LAs became responsible for commissioning local drug and alcohol services. This provided an opportunity to integrate prevention, treatment and support with other LA functions such as housing, crime, employment and education in order to improve an individual's recovery from substance dependence (Joint Commissioning Panel for Mental Health, 2013; Local Government Association, 2013b; 2014; Public Health England, 2015c). There is a real need to sustain high-quality services within the context of reducing budgets (Alcohol Concern, 2015; DrugScope, 2015; Public Health England and Association of Directors of Public Health, 2014).

**Across the four indicators tracking substance misuse, we draw attention to the following findings:**

- **Waiting times for substance misuse treatment have improved.** Over 95% of first interventions start within three weeks of referral and the average waiting time for accessing the service is 3.3 days (Public Health England, 2015d). The greatest improvements in waiting times have been in alcohol treatment: 78.2% of people waited under three weeks for treatment in 2009/10, compared to 95.4% in 2013/14 (Figure 2).
- Overall, **substance misuse treatment completion rates have improved, but this improvement has slowed** since 2012/13. The trend is different for different substances, and there has been a small decline in the percentage of opiate users completing treatment and leaving drug-free (8.8% in 2012/13 compared to 7.6% in 2014/15). The National Treatment Agency reports that this is a reflection of the entrenched drug use and long-standing and complex problems found in opiate users (Public Health England, 2015d). In contrast,



**Figure 2: Percentage of people waiting three weeks or less for first substance misuse intervention, England**



Source: Public Health England (2015d)

there has been an improvement in the percentage of alcohol users who leave dependence free (28.2% in 2009/10 compared to 39.5% in 2014/15). Treatment completion rates were highly variable across LAs.

- **Of real concern is the 5.0% increase in alcohol-related hospital admissions in England**, which rose to 645.1 per 100,000 population in 2013/14. The increase was significantly greater than would be expected based on the national trend in 21 LAs, but no clear pattern was found in terms of deprivation (Currie and others, 2015).

### 3. Smoking

#### Reduced prevalence of smoking, but a 45% decline in setting a quit date with local stop smoking services from 2012/13 to 2014/15

Smoking is estimated to cost the NHS £3.3 billion annually (Scarborough and others, 2011). However, smoking cessation and tobacco control interventions are the most cost effective of all public health interventions (Owen and others, 2012; NICE, 2008; All Party Parliamentary Group on Smoking and Health, 2015). From April 2013, LAs became responsible for commissioning stop smoking services and wider tobacco control, and a survey suggests that this has been useful for building relationships and better integration of tobacco control across council functions (Anderson and Cheeseman, 2016).

**Across the four indicators tracking smoking, we draw attention to the following findings:**

- From 2010 to 2014, there was a **steady decline in smoking prevalence among adults in England** (from 20.8% to 18.0%) and a decline in the percentage of mothers who reported smoking at the time of delivery (from 13.5% in 2010/11 to 11.4% in 2014/15). In the regional analysis, 13 LAs improved significantly more than would be expected based on the national trend. Four were found to have

improved less than would be expected based on the national trend, but there was no clear pattern in terms of levels of deprivation.

- From 2011/12 to 2014/15, **the number of individuals who set a quit smoking date with NHS stop smoking services declined** by 44.8%. The reasons for this are complex and are likely to reflect declines in prevalence, increasing use of electronic cigarettes by current smokers, and potentially lower primary care referrals into local stop smoking services.

## 4. Childhood obesity

### Declining obesity in young children (4–5 years), but no change in obesity in older children (10–11 years)

Obesity in childhood has significant consequences for mental and physical health. Health complications caused by obesity are estimated to cost the UK NHS more than £5.1 billion a year (Scarborough and others, 2011) and to cost English LAs £352 million a year in social care (Public Health England, 2015e). As of April 2013, LAs also became responsible for the delivery of childhood obesity programmes and other public health services for children (Department of Health, 2015b).

From 2009/10 to 2014/15, the **prevalence of overweight and obese children aged 4–5 years decreased** from 23.1% to 21.9%, while the prevalence of overweight and obese children aged 10–11 years has remained around 33%. There was regional variation in the trends by LAs, particularly among children aged 10–11 years, but there was no clear pattern in terms of levels of deprivation.

## 5. Immunisations

### Stable immunisations coverage, but further improvement needed in MMR uptake

All children in the UK are offered protection against a range of vaccine-preventable diseases. As of April 2013, responsibilities for the commissioning and delivery of immunisation programmes were delegated from the Secretary of State for Health to NHS England (Department of Health and NHS England, 2015). At a local level, DsPH are responsible for providing assurance to their local health and well-being board on immunisation uptake levels.

From 2010/11 to 2014/15 the uptake for childhood immunisations remained around 94% for diphtheria, tetanus, pertussis, polio and haemophilus influenzae type B (DTaP/IPV/Hib) at first birthday, and 96% at second birthday. **The coverage of measles, mumps and rubella at 2 years of age has improved over recent years, reaching 92.3% in 2014/15, but this upward trend has slowed.** Considering that the World Health Organization has recommended that at least 95% of children within a given population should be immunised to ensure protection, **uptake does need to improve.**

## Findings from survey and interviews

While the public health indicators provide an opportunity to track public health outcomes over time nationally and by LA, they cannot provide a wholly nuanced view of the recent changes and complexities involved in public health provision. Therefore, as well as using the survey and interviews to pin down the topic areas for investigation, they were also used to gather further information on the effects of recent system reform and funding pressures on public health services and functions.

### A mixed picture of opportunities and implementation difficulties following the H&SCA 2012

The survey evidence from senior public health professionals (n=37) indicated that the changes brought about by the H&SCA 2012 were generally welcomed as an opportunity to improve public health services through strengthened procurement by local government and greater opportunity to work across council functions. However, survey respondents also reported that the changed environment had led to organisational problems that may have had an impact on quality due to fragmentation of services across local government and the NHS, an increased burden of commissioning for LAs and providers, and reductions in the provision of public health input into NHS commissioning in some areas.

We now briefly discuss these themes using the survey responses and the in-depth interviews of senior public health professionals as well as providers and advocacy organisations. For additional analysis and interpretation, please see the full report.

### Commissioning for quality in a new environment: strengthened procurement

In the survey of senior public health professionals, 12 of the 37 respondents felt that the transition to local government provided an opportunity to improve quality and commission more effective and efficient services through re-procurement of some services. While recognising that it may be too early to tell what the impact on quality has been, senior public health professionals indicated that they felt that commissioning within local government provided:

- **greater transparency and increased scrutiny** as a result of the need to engage with lead council members for health and the public to justify decisions
- **greater freedoms within local government to address local needs** rather than a top-down approach:
  - “Local government is much better at procurement and contract management than the NHS. Once out of the NHS system it becomes apparent how stifling the top-down NHS approach to this is.” (Survey respondent)
- **greater focus on outcomes** and stronger performance management of providers:
  - “The increased discipline around commissioning and contracting, particularly the legal aspects, has been positive and in my view contributed to some increase in quality in large contracted services.” (Survey respondent)

- **greater emphasis on procuring services against specifications** and opportunity to encourage partnership working:  
“Improved effectiveness through more appropriate commissioning and alignment with other services (e.g. recovery-based drug services, stop smoking services more focused on disadvantaged groups, sexual health services integrated).” (Survey respondent)
- **a stronger emphasis on equity**, addressing the needs of more vulnerable groups:  
“The greater focus of [the] council on protected characteristics monitoring has provided some drive. Also, application of the Social Value Act to council commissioning impacts on local benefit.” (Survey respondent)

Perspectives from the providers and advocacy organisations were mixed: while recognising that some prevention services were in need of improvement or that the “quality of commissioning prior to transition was not brilliant” (interview respondent), the re-tendering process was seen to be disruptive in some areas:

“We have people who spent half their clinical time in a year doing nothing but working on the contract. That takes away from patient care.” (Interviewee)

It is difficult to demonstrate whether and how procurement of public health services within local government has had a positive impact on quality, because the system reform has taken place alongside marked reductions in budgets, which will have had a significant impact on the scope and quality of services provided.

### Greater opportunity for integration across council services to improve access and outcomes

Senior public health professionals reflected on the **improved opportunities to work across local government and influence the wider council agenda** brought about by the system reforms. This was felt to have had a positive impact on the wider determinants of health, from housing to transport. Wider partnerships have developed, including working with leisure services to emphasise prevention and health, working with trading standards to enhance tobacco control, and better integration across housing and substance misuse services to support recovery:

“Public health is now at the heart of all council services.” (Survey respondent)

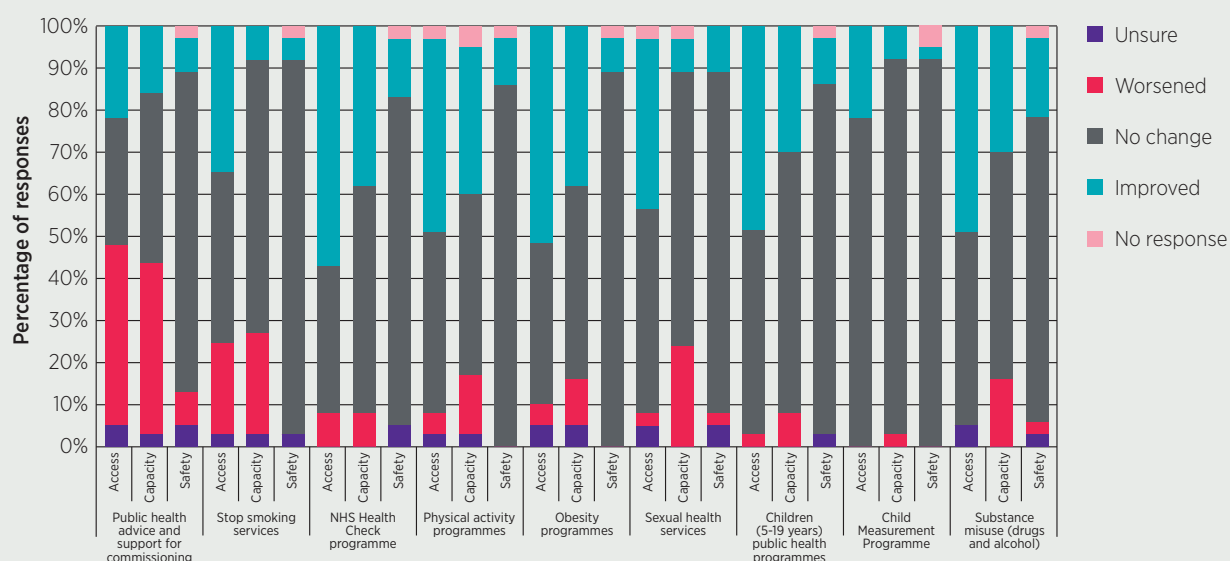
“The main improvement that has happened through moving to councils is not in commissioned services, but in opportunities to influence wider council areas, such as transport, leisure, planning regeneration etc.” (Survey respondent)

Furthermore, survey respondents suggested that access to many public health services that are now commissioned by local government had improved, including NHS Health Checks (21/37 responses, 56.8%), obesity (19/37 responses, 51.4%), substance misuse (18/37 responses, 48.6%), children’s public health services (18/37 responses, 48.6%), and physical activity programmes (17/36 responses, 45.9%) (Figure 3).

### A more fragmented system than before the structural changes took place

There was broad consensus that the structural changes following the H&SCA 2012 had resulted in **fragmentation of services and care pathways across multiple commissioners** (particularly for sexual and reproductive health and HIV and for

**Figure 3: Percentage of survey respondents reporting change in access, capacity and safety of public health functions transferred to local government since April 2013**



Source: QualityWatch DsPH survey (Nov 2015), n=37 responses

immunisation and screening programmes). It was felt that **this fragmentation had been further confounded by budget cuts**, resulting in the loss of supportive services that were previously able to signpost individuals, especially young people, into prevention pathways:

**“The infrastructure network of practitioners in local areas which supported young people into services like youth worker and Connexions have been cut, so the pathways into sexual and reproductive services in many areas have been fractured.”** (Interviewee)

### Loss of public health input into NHS commissioning

The H&SCA 2012 stipulates that each CCG is under a duty to obtain advice to support commissioning, and that public health teams in local government must provide public health input into local NHS commissioning (HM Government, 2012a; Department of Health, 2012). A public health approach, ensuring a focus on prevention and development of effective and efficient services in line with local population needs, is essential within the context of delivering the ambitions of the Five Year Forward View (NHS England and others, 2016).

Responses to the survey on this topic were mixed, with 16/37 senior public health professionals reporting that the public health input into local NHS commissioning had worsened following implementation of the H&SCA 2012. A further 11/37 respondents felt there had been no change, while 8/37 respondents felt it had improved.

**The financial pressures on public health could potentially have a negative effect on quality, which may in turn lead to tougher prioritisation decisions**

The most challenging issues facing services for improving public health, as expressed in the survey and interviews with senior public health professionals,

were the **detrimental effects of increasing financial pressures across local government and the NHS on service provision and quality, uncertainty over financial planning for public health, and concerns about the loss of skilled public health workforce:**

“Local relationships [are] currently very good but could be threatened by constant pressure on all parties. The council has shown great interest in public health and willingness to engage across all directorates, but financial pressure is huge and, even with the ring fence, councils across the region have sought to use public health funds to prop up other services.” (Interviewee)

“The risk is, as money is tight, people do not collaborate and share, but it is in everyone’s interest to get prevention right.” (Interviewee)

In addition, the following recurring themes emerged from the survey of senior professionals as being of key importance in the provision of public health:

- **the importance of prioritisation**
- **the need to invest in order to save**
- **commissioning to meet local needs.**

Some survey respondents raised concerns that tighter budgets would increase the difficulty of making prioritisation decisions locally. When asked about how prioritisation decisions might evolve locally, interview respondents gave the following examples:

- competition and **tension between the delivery of prescribed functions** (such as STI testing, treatment and provision of contraceptives) **and non-prescribed functions** (such as sexual health advice, prevention and promotion services)
- **decisions over whether to continue to fund clinical services where they may exist elsewhere** (such as treatment services within the NHS), potentially to the detriment of the health promotion element of public health
- **questioning the provision of services addressing perceived poor health choices by individuals** (such as substance misuse services) compared to those supporting frail older populations, for example
- decisions evolving through **political will.**

One respondent summarised the potentially detrimental effects of budget cuts on public health provision as follows:

“The NHS has a commitment to ‘prevention’ in the Five Year Forward View. However, national government has cut public health budgets – but much worse, the main purpose of transferring public health to local government was to address the wider determinants of health and wellbeing. The cuts to general local government budgets is frankly making this impossible and indeed worsening the situation. It is impossible to reconcile the rhetoric of the NHS and the government with regard to prevention with cuts in public health budgets and wider local authority budgets.” (Survey respondent)

## Conclusion

Public health services have undergone significant change in recent years following the implementation of the H&SCA 2012, the emphasis on prevention in the Five Year Forward View and recent cuts to public health funding. This report is a timely exploration of the quality of public health in light of these changes, and should serve as a useful reference point for assessing the quality of public health in England in the coming years.

Overall, we would like to emphasise the following points:

- The H&SCA 2012 resulted in significant restructuring of the public health system in England, and has been followed by cuts in funding across public health and local government as well as wider funding pressures in the English NHS. As yet, **there is little evidence of a marked change in public health outcomes resulting either from system reform or funding cuts**. This is not unexpected given the short period of time since the restructuring was implemented and financial pressures took hold. But as those financial pressures continue, **ongoing monitoring of outcomes at a local and national level is warranted**. It remains inherently difficult to ascertain the reasons for changes in quality or outcomes without more in-depth analysis of indicators within each area of public health, and an understanding of the drivers of this change at an individual, societal and population level.
- Some senior public health professionals expressed the view that **local government procurement processes place greater emphasis on integrated service models, alignment to quality standards, addressing the needs of vulnerable populations and enhanced performance management**. This was seen to contribute towards improving effectiveness, equity and access to services commissioned. However, this understanding should be considered alongside the perceived burden of commissioning reported by some providers and advocacy organisations.
- Aspirations to better link public health provision across council functions were expressed by some of the surveyed senior public health professionals. However, some also highlighted that **continued budget cuts could place a strain on working across provider organisations and commissioners to realise the potential of an integrated approach to health**.
- Some of the senior public health professionals surveyed and interviewed raised concerns that **financial pressures are likely to result in difficult prioritisation decisions within local government, with a potential detrimental impact on public health services, especially those serving vulnerable groups**. Joint commissioning between LAs and the NHS, strengthened leadership and better evidence to support return on investment in order to aid decision-making were highlighted by survey respondents as useful avenues for developing practice and protecting future public health services.

**The potential to improve the public's health by addressing the wider determinants of health within local government is well recognised, as is the NHS's commitment to prioritising prevention. However, system-wide financial pressures may mean these aspirations are difficult to achieve.**

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