NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We have over 220 members – more than 90% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

NHS Providers welcomes the committee’s inquiry into public health post-2013 Health and Social Care Act 2012 (the 2012 Act) reforms, given the critical role of public health and prevention, in optimising the wellbeing of our population and in supporting the sustainability of the NHS and public services more widely.

**Key messages**

- The devolution of public health responsibilities to local authorities under the 2012 Act allows for potential benefits in granting local areas the autonomy to determine how best to enhance public health outcomes for their populations.

- The new public health architecture is still bedding down and, if public health services are to successfully drive the ‘radical upgrade’ in public health described in NHS England’s *Five Year Forward View*, it is essential that services are properly resourced going forward. In this context, recent cuts to public health announced within the spending review are concerning.

- We understand that the government’s priority is to reduce the public sector deficit, and, as in the last parliament, NHS providers across the acute, ambulance, community and mental health sectors, are committed to playing their part in meeting the efficiency challenge.

- We support the commitment to increase the NHS budget by £10 billion in real terms and welcome the ‘front loading’ of the additional funding from 2016/17. This additional funding must, however, be considered alongside growing demand and the funding settlements for social care and public health services.

- In this context we consider that the link between public health and the NHS, both direct, in the form of the contracts held by NHS providers, and indirect, as a result of increased NHS costs if unhealthy behaviours are not tackled, needs to be fully appraised by the government.

- It is crucial to not see public health funding as entirely separate to NHS funding; the two are intrinsically linked and disinvestment in public health will undermine the ability of the NHS to deliver the change needed in the longer term.

**A- Health and Social Care Act 2012 and public health funding**

1. NHS Providers was supportive of the 2012 Act’s aim of transferring public health responsibilities to local authorities and appreciate the positive opportunities this creates, particularly in relation to integrating public health with mainstream local government plans and services, such as adult social care and housing.

2. Since April 2013, following the passing of the 2012 Act when around half public health spending was moved from the NHS to local authorities, a ring fence has applied to local authorities’ public health budgets. In the context of the government’s deficit reduction programme, this has ensured that public health has been protected from spending cuts. However it is worth noting that whilst increases in the government’s ring-fenced public health allocations in 2013/14 and
2014/15 were higher than real growth in funding than for the NHS, the allocation for 2015/16 was frozen in cash terms.

3. There is growing evidence of the benefits and return on investment of local authorities’ public health spending, as well as the implications for NHS resources of failing to invest in prevention – the King’s Fund and Local Government Association (LGA) have highlighted that unhealthy lifestyles cost the NHS billions of pounds a year with estimates that £1 in every £5 of NHS spending is dedicated to treating the consequences of poor public health.

4. In the time since the Health and Social Care Act was passed, public health has gained increasing recognition as centrally important to the long term sustainability of the NHS, with prevention positioned as integral to the realisation of the Forward View.

5. As such, the Forward View makes the case both for additional funding for the NHS to enable service transformation and investment in public health. Indeed, the separation of public health and NHS funding is an artificial one and many of the new care models set out in the Forward View focus on new integrated models of provision to support wellness promotion and health maintenance. Disinvestment in public health will undermine the ability of the NHS to deliver the change needed in the longer term.

B- 2015 spending review and public health funding

6. We welcome the Government’s commitment to increased the NHS budget by a further £10bn in real terms by 2020 and note the Chancellor’s reiteration within the spending review of the government’s commitment to delivering the Forward View in full. However, without corresponding resource available to deliver the ‘radical upgrade’ in public health the Forward View calls for, this additional NHS funding alone will not enable realisation of its ambitions.

7. It is therefore extremely concerning that almost £3.5bn of the £8bn extra funding for NHS England announced in the spending review will be funded through reductions to the Department of Health’s budget. The non-NHS part of the Department of Health’s budget, which includes Public Health England’s budget, will decrease by almost 11% next year, and an average annual reduction of just under 5% until 2021. Although full details of where cuts within this budget will fall are not yet available, the government has already confirmed that the public health budget held by the Department will be further reduced and it would be hard to imagine that there would not be further substantial cuts to Public Health England given how pressurised non-NHS health expenditure will be over the course of this parliament.

8. Whilst details of cuts to public health funding held by the Department of Health are not yet clear, the Chancellor confirmed in the spending review that average real terms savings of 3.9% to public health funding will be made over the next five years, resulting in in public health spending falling from £3.4bn in 2015/16 to £3.1bn in 2020-21. The spending review also sets out that the local government grant from central government will be reduced by £6.1bn by 2019/20. These cuts to public health spending, coupled with any further cuts that may be identified to non-ring fenced Department of Health funding for public health functions, will have a significant effect on the range and effectiveness of public health interventions,
9. Additionally, the government has confirmed it will consult on options to fully fund local authorities’ public health spending through their ability, granted within the spending review, to retain business receipts. There would likely be distributional consequences of such a move between local authorities using this tax, disadvantaging deprived areas with the highest needs for access to public health care. This will exacerbate reductions of 45% since 2010/11 of additional funding given to local authorities serving more deprived populations.

10. As local authorities are required to provide demand led services, such as sexual health treatment and treatment for drug and alcohol misuses, there is a real danger that proactive health promotion could be overlooked. This is especially important where local authorities, due to budget reductions, have had to cut other functions, such as leisure and park facilities, which may impact on public health.

11. In this context we are concerned that the ring fence for public health in this arrangement is only confirmed to be maintained until 2017/18, and this only applies to some elements of public health funding. A short term focus on tackling public sector finances in non-protected areas of the health budget, such as public health budgets, might inadvertently result in taxpayers paying more in the long run as a result of increased and more costly demand for NHS services. The Faculty of Public Health has estimated the cost to the NHS of the recently announced cuts to the public health budget to be over £1bn.

C- Public health reforms and NHS providers

12. NHS providers, in particular providers of community services, currently deliver public health contracts for local authorities. In the current financial context, where the provider sector is currently projecting a £2.2bn deficit by the end of 2015/16, small changes to a providers’ income can have significant implications for their future sustainability.

13. The Association of Directors of Public Health estimates that local authorities commission 40-80% of their public health services through NHS providers. The LGA states that councils would have “no choice but to pass these [public health funding] reductions onto providers and it will be impossible for these reductions to avoid hitting the NHS”.iii

14. Based on feedback from our members, the recent cuts to public health budgets are already leading to consequences for the contracts NHS trusts and foundation trusts they have in place with local authorities. Cutting or losing contracts in this way could potentially compromise their operating model and ability to put necessary capacity in place to provide public health services in future. For example, one community provider is forecasting a £0.9m reduction in turnover this year as a result of cut, which means that the provider will only be able to focus on areas of high deprivation (the top 10% low super output areas) which means there will be substantial reductions in services in areas which do not have high deprivation.

15. Given that many of the services threatened by the in-year cut to public health are also required by law, including alcohol and drug misuse, smoking and obesity, the funding cut is likely to have a significant impact on other services provided by the NHS, such as some sexual health services.

16. It is vital that local authorities work in partnership with NHS providers in their local area to understand how to best mitigate the impact of this cut for patients.

C2- Changes to commissioning of services
17. The movement of public health services away from the NHS services has the potential to change the nature of services commissioned by clinical commissioning groups (CCGs). For some services, different commissioning organisations are responsible for different parts of the pathway. For obesity services, for example, local authorities commission tier 1 and 2 services, whilst tier 3 is commissioned by CCGs and tier 4 by NHS England. This fragmented commissioning can result in difficulties in integrating the patient pathway and ensuring that people receive the care they need at the right time.

18. NHS annual planning guidance, due to be published in December, will likely require local health and social care economies to provide place-based multi-annual plans. This might provide an opportunity to align NHS England, CCG and local authority commissioning intentions within an area, and provide a clear strategy for how health, social care and public health services can be integrated.

_15 December 2015_

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