1. Introduction

1.1 NHS Clinical Commissioners (NHSCC), the membership body of Clinical Commissioning Groups (CCGs), welcomes this opportunity to submit evidence on the impact on public health post-2013 of the Health and Social Care Act reforms. Established in June 2012, NHSCC has just under 90% of CCGs in membership and offers a strong national voice for our members on a number of national policy issues. We support our members to be the best they can be in order to commission effectively for their local populations.

1.2 Our evidence for this inquiry is based primarily on the views and perceptions of our members, where possible we have brought wider research that supports our view. We therefore invite the Health Select Committee to read this submission as an insight from CCGs.

2. Main points for the Health Select Committee to be aware of:

- Since 2013 closer relationships have developed between local authority public health teams and CCGs, in part this has been due to local areas making the arrangements work. Where relationships are good, local areas are seeing improved outcomes for patients and populations.

- There is some variation and pressures on the development of Health and Wellbeing Boards that are preventing them from developing mature partnerships to effect change in public health including; the absence of co-terminosity in some areas, the lack of a single outcomes framework and the unclear role of Public Health England at a local level.

- A failure to adequately fund public health spending will have a significant impact on the effective operation of CCGs in their population health role and local health and care economies. CCGs are also concerned about the transparency and accountability surrounding the use of the ring-fenced public health budget. This will have a disproportionate effect on preventive work which has been identified as vital for both physical and mental health.

3. The delivery of public health functions & the effectiveness of local authorities in delivering the envisaged improvements to public health

3.1 The transfer in the commissioning of public health from the NHS to local authorities as part of the Health and Social Care Act 2015 created a lot of local upheaval at the time. While the move to making public health part of the wider determinants of the health and wellbeing agenda for local authorities was clear, the journey to making these arrangements work has been varied.¹ This has been partly due to local circumstances – populations, local authority/NHS boundaries, organisational relationships and workforce capacity. The impact for some CCGs has been a perceived loss of direct NHS input into the practice of public health commissioning at a local level.

Local relationships

3.2 In November 2014 we sought to gather a brief snapshot of the views of our members about the impact of the public health reforms on CCGs (see Annex for a summary of this survey²). Our survey found

¹King’s Fund “Has the government delivered a new era for public health?” April 2015 http://www.kingsfund.org.uk/projects/verdict/has-government-delivered-new-era-public-health

²Internal NHSCC membership survey November 2014. Note: The questions for this survey were developed with input from NHSCC members, the Association of Directors of Public Health (ADPH), Public Health England (PHE) and the Local Government Association (LGA). We had a 23% response rate which was low but we all agreed as organisations that the findings gave an early
that in the main the relationships between local authority public health and CCGs were developing well overall and supporting local commissioning, but this was often dependent on the personality and drive of the public health official allocated to the CCG. Much of the anecdotal evidence from the survey responses suggested that where CCGs felt there was a good level of support it was due to local personalities, existing relationships and individual champions. This led to some perceived variability in the levels of support.

3.3 The added value of public health advice and support in CCG plans when provided was perceived as beneficial overall. Most respondents to our survey (75%) reported that they found the advice they were given by local public health colleagues useful, with one quarter of respondents describing their advice as ‘somewhat useful’. Many CCGs have a public health representative on their Governing Body. Similarly, we found from our survey that the majority of CCGs have MOUs with their local public health teams outlining types of advice and support that the CCG will receive. 88% of surveyed Directors of Public Health agreed or strongly agreed that they were working well with their local CCG. 3

3.4 However, some of the feedback in our survey suggested that engagement with local authorities in their commissioning role with regards to public health was not as good, with a suggestion that in some cases there was tendency for local public health to “act in isolation” (see Annex).

The role of Health and Wellbeing Boards & effectiveness

3.5 This perceived distance from local authority public health commissioning is in part linked to the varied development of Health and Wellbeing Boards (HWBs). NHSCC has undertaken recent work to gather the views and perceptions of CCGs in relation to the development of HWBs; we have found that their quality and ability to shape the commissioning priorities of local areas varies quite considerably. In 2014 we published a document entitled A Shared Agenda 4 which highlighted the fact that HWBs in some areas were struggling to develop mature partnerships due to issues around:

- Dominant council processes and organisational culture differences between local authorities and the NHS
- Clarity around role and purpose of the Board
- A lack of parity amongst partners in decision making and their relative accountability to the local area.
- The relatively new establishment of HWBs.
- Co-terminosity of the local authority to CCG.

3.6 Variability in HWBs impacts on the delivery of local authority public health functions and equity for populations. Some CCGs are not yet seeing HWBs as culturally and structurally conducive environments for meaningful discussions about public health and wellbeing or prevention. As such, joint plans are not being developed and the CCG may be unaware/not consulted early on the strategic development of local prevention plans. 5

3.7 Some CCGs are realising the benefits of public health planning through mature partnerships. For example, we know of some areas where local pooling is taking place with local authorities around public health issues. In the North West a particularly strong relationship exists between Liverpool CCG and the

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local authority. So much so that the latter is heading the implementation of a central stream of the CCG-led Healthy Liverpool programme. This aims to make the city the most physically active core city and therefore improve the health outcomes and wellbeing of the local population. The joint programme was allocated £2.9 million of CCG investment as part of a pooled budget.6

Co-terminosity & fragmented commissioning

3.8 The issue of co-terminosity can also explain why CCGs can feel distanced from HWBs and the local public health commissioning agenda. This is where the HWB covers more than one CCG footprint. Our survey found that the majority (92%) of respondents felt that co-terminosity, or the lack of it, influenced the delivery of health and wellbeing for their population. Co-terminosity (where applicable) was seen as easier because it led to simpler and more productive relationships and allowed for fully integrated commissioning arrangements. Our members felt that a HWB that was too large would be limited in its ability to reflect local population circumstances, in some cases HWBs can be too big and unwieldy to enable anything other than high level strategic directions to be agreed.

3.9 One impact of this geographic and organisational distance from the NHS organisations is when local authorities procure public health services across large areas to seek better value for money. The procurement can result in fragmented services and the loss of coordinated provision with the NHS (particularly GP provision) – there are examples of this with obesity and sexual health services. Our member survey highlighted that the re-procurement of major public health services has been very widespread across local authorities (examples - integrated wellness services, drugs and alcohol, substance misuse, sexual health, school nursing, smoking cessation, health checks and weight management). Our members understood the need for the re-procurement but some (20%) have been unhappy about how this process has worked, particularly where it hasn’t allowed them the opportunity to input, has not joined up with other local plans, or where the re-procurement has had adverse effects on the financial position of local providers, who have lost contracts.

3.10 NHSCC feels that these local areas need to be supported to develop more sophisticated arrangements to develop public health plans with levels of local subsidiarity. We are working with the LGA to develop some joint messaging and development offers to HWBs to support this, and have released a recent report entitled Making it Better Together7 which shares some joint commitments and policy asks to support local areas to work effectively.

A single national outcomes framework to fully embed public health as a shared priority

3.11 If our view, public health has a critical role in supporting CCGs and local authorities in their population health and wellbeing roles. This role involves aligning outcomes across populations – examples will be improving life expectancy or reducing obesity which require whole system, multi-agency interventions. NHSCC and the LGA are keen to pursue the development of a national single outcomes framework for health, social care and public health8 which we feel will strengthen relationships at a local level and ensure HWBs are focused on shared local priorities and outcomes. It would also ensure that the NHS has a clear line of sight (co-commissioning ability) into local authority led plans for public health. This

outcome framework could set outcomes that are jointly owned by the NHS and local authority commissioning.

**The role of Public Health England (PHE) in supporting local public health**

3.12 The role of PHE and its interface with local public health is a key issue for local commissioners. CCGs would like to see more local visibility, with clarity on the local roles and accountabilities of PHE, including the scrutiny of local authority plans. In particular, more clarity was requested with regards to PHE’s role locally across the three domains of public health, particularly the domains of health improvement and population healthcare, so that CCGs had a better understanding about what they should expect of PHE in these areas.

3.13 We also feel that there may be a role for PHE to support Directors of Public Health, particularly with regards to scrutinising local authority spending plans, as it was felt that as local authority employees they may be under pressure to reflect the view that public health budgets have been protected. Stronger national leadership and coordination on issues such as alcohol minimum pricing and plain packaging for cigarettes was also requested. There was a more general appetite for PHE to have greater influence with national politicians to get traction on issues such as social responsibility.

**The public health workforce**

3.13 The public health sector is playing catch up on its workforce and for CCGs it feels as though the capacity and capability of local Directors of Public Health and local teams (medical and non-medical) are stretched. Our member survey in 2014 showed us that in some cases, where a Director of Public Health was covering a large area (and a number of CCGs), there would be heavy use of deputies who might not have the same level of knowledge. Similarly, some CCGs said they did not see anyone on a consistent basis due to a lack of capacity due to recruitment issues. Once again, this feedback highlights the feeling that overstretched capacity and insufficient resourcing is in some places having a detrimental effect on the ability of public health officials to provide valuable advice.

**4. Public Health spending**

**National priorities**

4.1 In the recent Spending Review the Chancellor announced 3.9% annual real terms savings over the next five years in local authority public health spending. It is suggested that these should be funded via an increase in business rates. This reinforces the prevalent view amongst local authorities that central government views prevention services as non-essential.

4.2 CCGs are acutely aware that public health is subject to budget cuts, both due to the overall financial situation of councils and a political system which focusses on the short-term. Our members view these cuts to public health spend as conflicting with the ambitions of the Five Year Forward View, which argues for ‘a radical upgrade in prevention and public health’ — it is a long-term ambition and one which our members fully support. However, the past five years have focused on de-fragmenting the commissioning system, balancing the finances of the hospital sector and improving the quality of hospital care. It is fair to say there

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has been a lack of national focus on longer term benefits of improved public health. For example, the government’s ring-fenced public health allocations to local authorities were relatively generous in 2014/15, with higher real-terms growth in funding than was allotted to the NHS.

4.3 In 2015/16 the government’s £200m in–year savings in public health will create immediate impacts and uncertainty for future budgets. The flat reduction across all Local Authority budgets is unhelpful since it fails to take into account local need, capacity, requirements, and potential. However, in this instance it was necessary in order to ensure clarity and ease of implementation. We are concerned that cuts to public health funding are greatest for areas with the largest health inequalities, these are often urban areas with the greatest need. The Faculty of Public Health has undertaken some analysis which shows 20 local authorities, including South Tyneside and County Durham, could be hardest hit by the cuts. The organisation estimated that County Durham could suffer cuts of around £6.25 per resident, while South Tyneside would see losses of £6.16 per resident. Following the 2015 Spending Review, it remains to be seen whether these savings will be recurrent year-on-year, or whether these fall outside what is considered to be the ring-fenced budget for 2016/17 and 2017/18.

4.4 The protection of public health budgets is important as it impacts on partnership working between the CCGs and local authorities on the ground. Cuts can lead to vital services becoming fragmented as more and more procurements are driven by cost saving as opposed to the best local suppliers. In some cases, CCGs will need to step in to fill voids. This will lead to an increase in cost for CCGs and have a knock-on effect for the whole health and social care sector. Investing in prevention reduces pressures on both health and social care services and will increase economic productivity.

4.5 Reducing public health funding also risks CCG transformation and strategic planning. Public health plays a vital public role in publishing and profiling the JSNA (Joint Strategic Needs Assessment) in levels of detailed analysis which actively contributes to the local health and care systems strategic investment planning, as well as immediate decisions. For example, in some cases CCGs have included health expertise in transformation programmes, this would include public health indicators of success, and specific recommendations on where to invest in community resilience on a locality by locality basis in relation to deprivation.

Use of the public health ring fenced budget

4.6 There is a concern amongst our members regarding the level of local authority resource available for public health. Many local authorities have been cutting their wider functions, such as leisure and park services, many of which impact on the public’s health.

4.7 A particular concern for CCGs is the transparency around the public health ring fenced budget. In our member survey in 2014, we found that whilst there was a good level of awareness amongst respondents regarding the statutory conditions for the use of the public health ring-fenced budget, concerns were expressed by some about the transparency and accountability of its usage locally. It was suggested that the underlying pressures facing local authorities meant that the funding was being used to cover services that had previously been paid for out of local authority allocations, rather than on protecting public health.

15 King’s Fund “Improving the public’s health” http://www.kingsfund.org.uk/projects/improving-publics-health
4.8 For example, a recent article and investigation from the British Medical Association suggested that some local authorities were using ring-fenced money to maintain other threatened services.\textsuperscript{16} Thereby redefining public health in a different way to maintain existing services. This reduced the funding for some pre-existing public health work and increased the perception in CCGs that the funds are being used for activities they are not intended for.

4.10 The NAO has also suggested\textsuperscript{17} PHE needed to do more to 'ensure that authorities use their grant effectively in order to meet the specific health demands within their areas'. It may be that PHE need to have a role scrutinising local authority spending plans and the evidence base used for decisions to better protect public health spending locally. The concerns about the politicised process of public health decisions can be seen in a survey of public health teams which found that 59% of respondents felt that health decisions were based on political process rather than purely on the evidence base.\textsuperscript{18}

\textit{Submission ends}

\textit{16 December 2015}

\textsuperscript{18} RSPH "The views of public health teams working in local authorities Year 1" February 2014 https://www.rsph.org.uk/filemanager/root/site_assets/about_us/reports_and_publications/the_views_of_public_health_teams_workin_g_in_local_authorities.pdf
Introduction

CCGs have been delivering high quality care for patients and local populations since establishment, and are taking an ever more integrated whole person approach involving a wide range of key players in their local health economy, including public health.

NHSCC developed a member survey in late 2014 to understand (following member concerns) how the arrangements and relationships with public health are working and what members’ experiences are delivering against public health determinants.

The following survey report gathers findings based on member experiences exploring the opportunities and difficulties when working with local public health and the extent to which CCGs feel it is increasing members’ understanding and ability to improve the health and wellbeing of their patients and local populations.

The survey

The member survey was designed between July and November 2014. It went live on 17 November and ran for a month, until 18 December. It was targeted at CCG clinical leads and accountable officers.

The questions were developed with input from NHSCC members, the Association of Directors of Public Health (ADPH), Public Health England (PHE) and the Local Government Association (LGA).

The survey received a relatively low response rate, with a total of 48 responses from approximately 40 CCGs (some respondents did not state their CCG). This was 23% of NHSCC’s membership. There was regional variation in the responses, with over half (55 per cent) coming from Yorkshire, Humber and the North West. There were no responses from the East of England and South Central. The low overall response rate could be due to the length of the survey, which was 23 questions long with further room for free text. It could also be due to the timeframe of the survey, which coincided with announcements about primary care commissioning, which will have affected commissioners.

Due to this relatively low response rate it is important to recognise that the findings of this report are not conclusive or representative of all CCGs. Nonetheless, it does provide a valuable insight into the perceptions of some CCGs with regards to their relationships with public health officials.

1. The relationship between local authority public health and CCGs

The relationships between local authority public health and CCGs is developing well overall but is often dependent on the personality and drive of the public health official allocated to the CCG. This leads to variability in levels of supportiveness. There is concern regarding the level of local authority resource available specifically for public health.

Although those who responded felt that local public health colleagues were, in the main, supporting CCG commissioning positively, a third described them as only ‘somewhat supportive’. Much of the anecdotal evidence from the survey responses suggests that where CCGs felt there was a good level of support it was due to local personalities, existing relationships and individual champions. Some responses clearly highlighted that the level and quality of support received was highly dependent on the person allocated to support the CCG. There were concerns expressed about resources, which were described as having “diminished over the two years of public health being in local authority and a locality focus somewhat lost”.

(Please note this was a product that was shared with our members only)
The survey highlights evidence of ‘added value’ from public health input into CCG commissioning plans. Most respondents (75 per cent) reported that they found the advice they were given by local public health colleagues useful, with one quarter of respondents describing their advice as ‘somewhat useful’. However, some of the feedback suggested that engagement with local authorities in their commissioning role with regards to public health was not as good and it was suggested that there was tendency for them to “act in isolation”.

Advice from public health is being embedded or integrated into CCG’s plans. Survey respondents identified factors including; focussing on specific pieces of work; strong Joint Strategic Needs Assessments underpinning work; and a Director of Public Health who sat on the CCG governing body. The barriers that were identified highlighted concerns about local authority public health funding, particularly regarding diminished resource, capacity and expertise.

The results of the survey showed that Directors of Public Health were well represented amongst the CCG governing bodies that responded, with 37 per cent reporting that a Director of Public Health sat on the governing body and 22 per cent a senior consultant. However, the majority of these public health representatives did not have voting rights, in fact only nine per cent of Directors of Public Health and seven per cent of consultants had voting rights across all the CCGs that responded. More significantly, 26 per cent of boards didn’t have any public health representatives on them. The absence of public health representation altogether could be a reason behind some CCGs feeling that they are not receiving the advice and support they would expect from local authority public health officials.

Local public health officials are considered useful and effective in their interactions with CCGs but at times deputies are regularly sent, who are often less knowledgeable. A lack of capacity and concerns about resource were undermining effectiveness in some places.

Amongst those who did have a public health representative on their CCG governing body, experiences included them being considered ‘very effective’, a ‘useful challenge’ and a ‘valued opinion helping to shape direction of the CCG’. A very positive respondent said the “DPH is our conscience and keeps us focussed on the needs of our population in our debates and decisions”. However, barriers included DPHs consistently sending deputies, who might not have the same level of knowledge, as well as a lack of capacity due to recruitment issues. One respondent suggested many staff were not keen to work for the local authority and that one Director of Public Health might cover several CCGs. Limited resources and concerns around sustainability were also raised. Once again, this feedback highlights the feeling that overstretched capacity and insufficient resourcing is in some places having a detrimental effect on the ability of public health officials to provide valuable advice.

Local memorandums of understanding with public health teams are now commonplace, with 95 per cent of respondents reporting that they have, or are developing, a memorandum of understanding with their local public health team that outlines the types of advice and support the CCG will receive.

2. The public health ring fenced budget

There was a good level of awareness amongst respondents regarding the statutory conditions for the use of the public health ring-fenced budget. However, there were concerns expressed by some about the transparency and accountability of its usage locally, as well as some worry that the underlying pressures facing local authorities meant it was being used to cover services that had previously been paid for out of local authority allocations, rather than on protecting public health.

Overall, CCG respondents were aware of the statutory conditions for the use of the public health ring fenced grant in their area. However, responses suggested varying levels of understanding of the conditions, with only 29 per cent saying they had a ‘good understanding’ and 34 per cent saying they only had some understanding of these. Twenty-seven per cent said they were aware of the conditions but didn’t know the detail and 10 per cent said they had no awareness at all. These results suggest that there is a lack of clarity amongst some CCGs with regards to the statutory conditions for the usage of the public health ring-fenced grant.
This view is further reflected by respondents who have said that “greater clarity would be welcomed so we can work to ensure the grant is protected for public health commissioning”. This seems particularly important given the suggestion that the funds are being used for things previously paid for out of local authority allocations. Whilst there was widespread recognition for the context of cuts and the underlying pressures facing local authorities, many respondents were still worried about losing investment in prevention and expertise, and the effect this could have on public health services locally in the long term. For instance, in one area it was highlighted that because the grant is being used for things previously funded out of other local authority allocations, it has meant “reduced funding for some pre-existing PH work”. Another respondent suggested that “public health funds have been used to support wider county council activities.” Concern about the usage and operation of the grant has led several CCG respondents to agree that there is a need for greater transparency and accountability over the use of these funds, to ensure they are not inappropriately diverted to pay for things they were not intended for.

Further to this, some respondents also felt that Public Health England had a role in providing proactive support for Directors of Public Health who are sometimes being put in a very difficult position by their local authority employers, asking them to sign up to statements saying that public health budgets have been protected. It was suggested that more action needed to be seen from Public Health England with regards to scrutinising local authority spending plans and the evidence base for decisions to better protect public health spending locally.

3. Public health procurement

The re-procurement of major public health services has been very widespread across local authorities. Overall the need for procurement was understood amongst members but some have been unhappy about how this process has worked, particularly where it hasn’t allowed them the opportunity to input, has not joined up with other local plans, or where the re-procurement has had adverse effects on the financial position of local providers, who have lost contracts.

Seventy-two per cent of respondents said that local authorities have re-procured major public health services, including integrated wellness services, drugs and alcohol, substance misuse, sexual health, school nursing, smoking cessation, health checks and weight management.

Whilst the majority were satisfied, 20 per cent of respondents were unhappy about how the re-procurement process worked and highlighted concerns around CCG engagement in the process. They reported that this did not allow sufficient time for their input into service design of the procurement process, a lack of join up with other plans and concerns around the financial impact on acute providers if they were to lose the tender, leading to stranded costs and adding to an already dire financial position.

4. Relationship of public health to the wider system

Directors of Public Health are making inroads into being seen as influential champions on public health issues and raising their profile amongst those that they engage with in the local authority and health communities. They are, however, not having the same perceived influence amongst people in the community. This could be linked to capacity issues which have been highlighted.

There was a very consistent view expressed amongst respondents on the extent to which the Director of Public Health was felt to be an influential champion on public health issues in the local authority, health community and wider community. Whilst the majority of respondents agreed that the Director of Public Health was an influential champion on public health issues amongst the local authority and health community, respondents didn’t feel the same was true of their ability to influence and be the champion on public health issues in the wider community, Directors of Public Health’s visibility in the community tended to be seen as low, although there were exceptions to this where they were leading or involved in specific public health programmes locally. The overall lack of public visibility could be due to some areas not having a Director of Public Health on their CCG governing body, making it harder for CCGs to be aware of the work done by them.
However, the results do imply that in some areas, Directors of Public Health are making inroads into successfully highlighting the importance of public health issues and raising their profile amongst those that they engage with regularly in the local authority or health sector, but that they are not having the same perceived success amongst people in the community.

Looking more closely at the perceived barriers, as well as the enabling factors which facilitate Directors of Public Health being regarded as influential champions, respondents highlighted that where the Director of Public Health was seen as being influential, it was often down to personal charisma and having the ability to influence and champion public issues themselves. Having a direct link to the local authority Chief Executive was also seen as positive.

Respondents highlighted several perceived barriers, which were felt to have affected the ability of Directors of Public Health to be influential, including public health being seen as a low priority by some councils and therefore less resource being made available for it. Responses also suggested that where the Director of Public Health was a non-executive it was proving ‘challenging’ as they had less influence within the local authority. Issues were raised about their ability to have strategic influence on other council directorates and there was a suggestion that their role appeared constrained by being within the local authority. Once again, where the Director of Public Health covered a significant geographical area, this was also seen as a factor that often limited their capacity to input or influence locally.

Some of the respondents highlighted that Public Health England not only had a national role with regards to public health, but also a local role in improving the ability of Directors of Public Health to be influential, with regards to public health issues. They saw this as entailing the provision of locally applicable tools on vital public health issues, such as healthy eating, smoking cessation and substance misuse. Furthermore, they suggested that Public Health England could take action to become more influential on local authority decision making on housing and education and have greater influence with politicians to get traction on issues such as social responsibility.

5. CCG and Health and Wellbeing Board relationships to support prevention

CCG relationship with the Health and Wellbeing Board

The majority of respondents reported that the local public health strategy and agenda was an ‘active contributor’ to the activities of their health and wellbeing Board and all respondents felt that public health had at least some input into the work of their board. There were also positive responses from CCGs with regards to their perceived involvement and ability to influence decisions on public health locally. The majority of CCGs said that they had ‘some ability’ to influence decisions on public health locally and a quarter felt ‘very able’ to do this. Only a few responses suggested they had ‘no ability’.

Some pooling of CCG and local authority budgets is taking place and all respondents suggested that there was either already some alignment of commissioning priorities to pooled budgets or they were discussing it with their local authority. Public health was also seen as being involved or even ‘leading the way’ in the implementation of Better Care Fund planning, in over half of respondents’ areas. However, 41 per cent of respondents still felt that public health had only been ‘minimally involved’ in this, with one response suggesting it wasn’t involved at all.

Culture and structure of the Health and wellbeing board

Every CCG respondent was engaged with their health and wellbeing board and the majority (75 per cent) felt the relationship they had added ‘good’ or ‘very good’ value to the functioning of the board. This was particularly true where the relationship was underpinned by long established partnership working between the local authority and the CCG. However, there were mixed views on the conduciveness of the structure and culture of health and wellbeing boards to supporting prevention.

Nearly half (49 per cent) of all respondents thought that the culture of the health and wellbeing board was not conducive to improving the health and wellbeing of their populations and 41 per cent didn’t think the
structure was conducive to this ambition either. Responses highlight the view that health and wellbeing boards are at varying stages of development. One respondent emphasised that they were “nowhere near ready to take on responsibility for the NHS locally”. Further to this, respondents suggested that the structure and culture often felt council dominated, with the CCG not being seen as an equal partner. This was echoed in other comments, which described the boards as “very staid and embedded in council culture” another making the point that “the health and wellbeing board has a built in majority, so if any issues ever came to a vote the local authority will be assured it will win”. Other remarks included the view that “the health and wellbeing boards are led more by the local authorities than the NHS”. Looking specifically at the structure, the large size of some boards was seen as a challenge to decision making and one respondent said that “it is difficult to have a feeling of localism for all areas that the board covers”.

Co-terminosity

Overall, the survey showed that co-terminosity between the CCG and the local authority/authorities was an enabler to local delivery, when occurring at the right level. The majority (92 per cent) of respondents felt that co-terminosity, or the lack of it, influenced the delivery of health and wellbeing for their population. Co-terminosity was seen as positive because it led to simpler and more productive relationships and allowed for fully integrated commissioning arrangements. However, it was felt that where the needs assessment is carried out at a county level it is difficult to translate at a local level, for example in one case there were six CCGs within the health and wellbeing board county. The negative impact of this was suggested further by another respondent who said that a “county who covers four CCGs often pushed towards a one size fits all approach”. Respondents suggested that a HWB that was too large could be limited in its ability to reflect local circumstances, with only high level strategic directions agreed. Large health and wellbeing boards were “too big and unwieldy to enable anything other than high level strategic directions to be agreed”.

6. What CCGs would like to see for Public Health from national bodies in light of the Five Year Forward View

CCG respondents highlighted several things that they would like to see done for public health by NHS England and Public Health England in light of the Five Year Forward View. Specifically from NHS England, they highlighted the need for greater clarity around systems and accountabilities for public health responsibilities held by NHS England. Protection for public health allocations, for example ensuring that any allocations are subject to health and wellbeing board approval, was also seen as important. They emphasised the need for prioritisation of public health indicators, such as health inequalities, focus on and investment in prevention, and support for the enablement of place-based leaders to make investments upstream and build local relationships.

From Public Health England, respondents signalled that they would like to see more local visibility, with clarity on the local roles and accountabilities of Public Health England, including the scrutiny of local authority plans. In particular, more clarity was requested with regards to Public Health England’s role locally across the three domains of public health, particularly the domains of health improvement and population healthcare, so that CCGs had a better understanding about what they should expect of Public Health England in these areas. Respondents also wanted more proactive support from Public Health England for Directors of Public Health, particularly with regards to scrutinising local authority spending plans, as it was felt that as local authority employees they may be under pressure to reflect the view that public health budgets have been protected. Stronger national leadership and coordination on issues such as alcohol minimum pricing and plain packaging for cigarettes was also requested.

However, long-term sustainability was also seen as a major issue amongst CCGs. Respondents recognised that public health will inevitably be subject to budget cuts, both due to the overall financial situation of local authorities and because of the nature of the political system which focuses on short-term pressures. Further to this, some CCGs suggested that the tight financial situation in public health is in conflict with the longer term ambitions of the Five Year Forward View, in which prevention and public health plays a central role for achieving sustainability.

NHS England:
Clarity around expectations, accountabilities and governance for public health work

Protect public health allocations, for example by ensuring they are subject to health and wellbeing board approval

Prioritise public health indicators such as health inequalities

Focus and investment in prevention

Enable place-based leaders to make investments upstream and build local relationships.

Public Health England:

More local visibility

Clarity on local role and accountabilities of Public Health England

Scrutiny of local authority plans

Proactive support of Directors of Public Health, who as local authority employees may be under pressure to say that public health budgets have been protected

Strong national leadership/coordination on issues such as alcohol minimum pricing and plain packaging for cigarettes.

7. Conclusion

Overall, our member survey had a low response rate but the findings were positive with regards to the developing relationships between CCGs and local public health. Responses suggest that there is a good level of support given by public health, with useful and effective representation on CCG boards. Directors of Public Health are on the whole making progress in influencing and championing public health issues and raising its profile within the local authority and health communities. Furthermore, public health is making an active contribution to the activities of the health and wellbeing board, helping to align priorities as well as engaging and even sometimes leading the way with regards to the implementation of Better Care Fund planning. However, whilst there is much that is positive here, there are also some serious concerns, particularly with regards to the capacity of public health officials in some larger areas, where they cover more than one CCG and also in those areas where respondents reported that there were no public health representative on the CCG board at all.

Money is obviously an important concern, with some CCGs believing that reduced local authority funding will make a squeeze on the amount of money available for public health inevitable, particularly in areas with councils that do not see it as a priority. Responses to questions around the statutory conditions for using the ring-fenced public health grant strongly highlighted these concerns. Greater clarity, as well as greater transparency and accountability for the ring fenced grants usage, is seen as vital for ensuring the funds are protected for public health commissioning in the future. Whilst there is widespread recognition for the underlying pressures facing local authorities, overall CCGs still have serious worries about losing investment in prevention and expertise and the effects this could have on public health services locally in the long term.

There are also some areas of the survey, which highlight the need for improvement, development and support. This is seen particularly with regards to the quality of advice and support that public health officials provide to CCGs and in terms of the levels of influence, which are both seen to be quite dependent upon the personality, drive and enthusiasm of the individual involved. There is also evidence to suggest that Directors of Public Health are not having the visibility and influence that they should have amongst the local community and that there is room for more local and national support from Public Health England to enable them to have greater visibility and influence. Furthermore, there is evidence that the current structure and
culture of the health and wellbeing board is acting as a barrier to supporting prevention, particularly as it is felt to be too local authority dominated.

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