National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health and Public Health England

Public Health England's grant to local authorities

HC 888 SESSION 2014-15 17 DECEMBER 2014

Our vision is to help the nation spend wisely.

Our public audit perspective helps Parliament hold government to account and improve public services.

The National Audit Office scrutinises public spending for Parliament and is independent of government. The Comptroller and Auditor General (C&AG), Sir Amyas Morse KCB, is an Officer of the House of Commons and leads the NAO, which employs some 820 employees. The C&AG certifies the accounts of all government departments and many other public sector bodies. He has statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively, and with economy. Our studies evaluate the value for money of public spending, nationally and locally. Our recommendations and reports on good practice help government improve public services, and our work led to audited savings of £1.1 billion in 2013.

National Audit Office

Department of Health and Public Health England

Public Health England's grant to local authorities

Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 16 December 2014

This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

10 December 2014

HC 888 | £10.00

This report examines whether the new public health grant to local authorities is likely to lead to intended outcomes and achieve value for money.

10589 12/14 NAO

Contents

The National Audit Office study team consisted of:
Jemma Dunne, Jenny George and Andy Serlin, under the direction of Robert White with the assistance of Sophie Judd, Amisha Patel and Nicholas Todd.

This report can be found on the National Audit Office website at www.nao.org.uk

For further information about the National Audit Office please contact:

National Audit Office
Press Office
157–197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Tel: 020 7798 7400

Enquiries: www.nao.org.uk/contact-us

Website: www.nao.org.uk

Twitter: @NAOorguk

Key facts

£5.8bn
total Department of Health funding for public health in 2013-14

£2.7bn
Public Health England's grant to local authorities for public health in 2013-14

152
local authorities spending public health grants from Public Health England

1 April 2013	Public Health England established (implementation of the Health and Social Care Act 2012)
£3.5 billion	estimated annual cost to the NHS of alcohol-related harm in England
52.5 to 70 years	range in healthy male life expectancy in local authorities in England
£5 million	value of the health premium incentive in 2015-16
68	public health outcome framework indicators of health and wellbeing, supported by 196 measures
2.8 million	people offered an NHS Health Check in 2013-14

Summary

The new public health arrangements

1 Public health is about helping people to stay healthy and protecting them from threats to their health. Public health activities include protecting the public's health from hazards and infectious diseases, improving the public's health through encouraging healthier lifestyles, reducing the large health inequalities across England and promoting health as part of healthcare services. Improving health and wellbeing creates a more economically and socially active population and reduces the burden on the NHS and the economy. For example, alcohol misuse alone costs the NHS more than £3 billion each year. Our previous work has highlighted the need for early action.[1]

2 The Health and Social Care Act 2012 was implemented from 1 April 2013. This made fundamental changes to the system for funding and delivering public health. The government felt local authorities were best placed to design services to meet local needs. Responsibility for commissioning local public health services therefore returned to local authorities from the NHS. Local authorities now have a statutory duty to improve the health of their populations. The Department of Health (the Department) is still responsible for public health policy. The Department also created a new operationally autonomous national executive agency, Public Health England (PHE).

3 PHE has been set up as the expert public health agency and is intended to have an authoritative voice on all public health issues, including health protection and improving public health. It provides local authorities, the Department and the NHS with advice and evidence on what works best in protecting and improving public health. In addition, it provides a range of central services, including health protection and public health surveillance, and social marketing campaigns. PHE will be held accountable for securing improved public health outcomes.

4 In 2013-14 PHE gave local authorities £2.7 billion via a ring-fenced grant to carry out their new public health responsibilities. The Department determined each local authority's share of the grant based largely on previous patterns of spending by primary care trusts. It set 6 functions that local authorities must have in place, so there is greater uniformity of services and the Secretary of State's legal duties are met. Within these constraints, local authorities have discretion over how best to spend the grant to achieve better local public health outcomes. They are responsible to their electorates for those decisions.

1 Comptroller and Auditor General, *Early action: landscape review*, Session 2012-13, HC 683, National Audit Office, January 2013.

5 This report examines whether PHE's arrangements for the £2.7 billion ring-fenced grant funding to 152 local authorities are likely to lead to intended outcomes and value for money. Our focus is on PHE's role in supporting local authorities. We have not audited local authority provision of public health services. Our audit approach and evidence base are summarised at Appendices One and Two.

Key findings

Local authority public health spending and outcomes

6 PHE has made some key achievements during its first year including supporting local authorities in their new role. A survey of stakeholders found that three-quarters of respondents have a good working relationship with PHE. Public health responsibilities transferred successfully from primary care trusts to local authorities as at April 2013, although it is generally too early to tell whether public health outcomes are improving. Recent data on NHS Health Checks show improvement in service provision, with checks now being offered by every local authority. PHE has supported local authorities in their public health roles in a variety of ways, including through advice and analysis tools (paragraphs 2.16, 4.3, 4.5, 4.11 and Figure 8).

7 The new public health arrangements have increased transparency of public health spending, improving understanding of the services provided in each local authority. Previously, primary care trusts received a single funding allocation to provide health and public health services. But the Department did not routinely collect full data on public health spending. Under the new arrangements, the Department carried out a baseline exercise to identify public health spending, highlighting differences between local areas. Local authorities now report their public health spending data using 18 categories, which aids comparison between areas (paragraphs 2.3, 2.8 and Figure 3 on page 15).

8 Public health funding increased by 5.5% in 2013-14, and the Department's funding allocations are moving closer to target allocations that reflect local needs. The Department increased public health funding by more than inflation in 2013-14 and 2014-15, reflecting the importance it attaches to public health. But if spending is not directed towards the greatest public health challenges then it is harder to achieve value for money. Historic local decisions on public health funding by the NHS have left some local authorities receiving a significantly greater or lesser proportion of the funding than they would have been allocated if based on need. In 2013-14, 51 of 152 local authorities were more than 20% from their target allocation (decreasing to 41 for 2014-15 and 2015-16). The Department is moving funding allocations slowly to promote stability of existing services (paragraphs 2.3 to 2.5 and Figure 5).

9 **Some local authority spending decisions are not yet fully aligned with areas of concern.** Spending on different aspects of public health varies significantly between local authorities, which is not surprising given local autonomy and differing needs and circumstances. Our data analysis showed local authorities where alcohol misuse worsened the most between 2010-11 and 2012-13 were spending significantly less on alcohol services in 2013-14. PHE has developed useful tools for local authorities to use to understand their public health needs and spending. It will need to use these available data to inform its own approach going forward. Without strong levers, PHE needs good information so it may target its support to those local authorities that most need it (paragraphs 2.7 to 2.8, 2.11 to 2.12, 4.9 to 4.10 and Figure 6).

10 **The Department has not decided how long the ring-fence will remain in place, and the impact, if removed, is uncertain.** Returning public health to local government brings opportunities for greater integration of public health into wider government spending, such as social care, housing and environmental protection. It also brings risks. Historically, local authorities funded some activities that promote public health from their local budgets. Government funding for local authorities has fallen by 28% in real terms over the 2010 Spending Review period. Some directors of public health talk about the pressure to fund some of these activities through the ring-fenced grant. There is a risk that total public health spending will decline as local authorities face continued budget reductions (paragraphs 2.13 to 2.15).

Governance and accountability arrangements

11 **There have been some problems with the provisional local authority spending data on public health.** PHE is accountable for the public health grant and has set up a framework of assurance measures. Local authority provisional spending data are not available until 5 months after the year-end, and the quality of some provisional data on public health spending was flawed. For example, 81 local authorities initially reported nil spending against 1 or more of the 6 prescribed public health functions. PHE did not thoroughly investigate these data problems when budget data were released in July 2013. PHE and the Department for Communities and Local Government have been working with local authorities to improve the quality of their final spending data (paragraphs 3.2 to 3.5).

12 **The public health outcomes framework brings together public health datasets for the first time, increasing transparency and accountability, but some data limitations persist.** Local authorities are responsible for securing their own public health outcomes. The Department has designed a comprehensive outcomes framework that allows comparisons of performance and therefore increases accountability. Directors of public health frequently use the framework although there are time lags of at least 18 months for publishing much of the data (paragraphs 3.6 and 3.8 to 3.10).

13 PHE has two formal levers to secure the improved public health outcomes for which it will be held to account. PHE's remit to report performance against the public health outcomes incentivises local authorities by clearly showing their relative performance and needs. From 2015-16 PHE will also administer an incentive payment system called the health premium. However, the autonomy of local authorities gives no guarantee that PHE can secure improvements in outcomes and at £5 million, the health premium risks being too small to bring about significant change (paragraphs 3.2, 3.6 to 3.12 and Figure 11).

14 The Department's approach to holding PHE to account through its accountability meetings and a scorecard is generally good. The Department holds quarterly assurance meetings with PHE, discussing a scorecard that tracks 97 indicators across a range of activities. However, the Department does not assess PHE's progress on influencing Whitehall on public health issues. We also saw a minority of examples where indicators giving cause for concern were not discussed at these meetings, although PHE told us that these were addressed elsewhere (paragraphs 3.13 to 3.15).

Supporting and advising local authorities

15 PHE was set up to be the nation's expert agency on public health; its system leadership on health improvement is growing, but could develop further. PHE has worked well to establish itself at the centre of the new public health system, with its published priorities for public health receiving widespread stakeholder support. Public health is also a prominent theme in the recent NHS 5-year forward view. Several bodies have a role in public health, leading to some confusion. Some stakeholders think PHE should display stronger system leadership over specific issues such as helping commissioners and providers to resolve problems caused by fragmented responsibilities for certain public health services (paragraphs 4.11 to 4.13).

16 PHE supports local authorities through both advice and evidence tools, and is particularly strong on support on health protection. PHE has set up local centres to support and advise local authorities. In our survey, 98% of directors of public health rated the centres highly for their support on health protection issues. But directors of public health did not feel they got enough support from PHE centres on engaging with their local clinical commissioning group, or from PHE's knowledge and intelligence teams. PHE provides a number of tools and national evidence-based products such as local data on premature mortality, which local authorities may use to support their local decisions. PHE also provides regional reports that highlight regional variance in outcomes (paragraphs 4.3 to 4.6 and Figure 12).

17 PHE has not yet formally documented its many influencing activities into prioritised strategies. PHE has engaged regularly and widely across local authorities and Whitehall, including using senior-level engagement to discuss key issues and priorities. The formal levers available to PHE for securing better public health outcomes are limited, which means influencing local authorities and wider stakeholders is crucial to its success. It has not yet documented a coordinated plan that prioritises who it wants to influence. PHE has not yet set out how it might adapt its influencing approach in future if the ring-fence were to be removed (paragraphs 4.2, 4.8, 4.10 and 4.14 to 4.15).

18 In early implementation of the new public health arrangements, staffing and structures have presented challenges for PHE and local authorities. The quality of public health interventions depends on the structures and capacity within PHE and local authorities. PHE was formed with staff from more than 100 bodies, so soon after its inception it carried out a strategic review of its structure to establish how it could remain fit for purpose in future. This found that the current set-up requires change. Planned changes aim to improve clarity around roles, purpose and governance. Directors of public health felt that public health is generally well-placed within local authorities. Staffing has been difficult pre- and post-transition. At local authorities, interim positions still account for 16% of directors of public health, with those permanently employed at a level similar to that previously seen within primary care trusts. Unequal terms and conditions have led to significant dissatisfaction among some public health professionals (paragraphs 4.16 to 4.21).

Conclusion on value for money

19 PHE has made a good start at building effective relationships with local authorities and other stakeholders. By design, PHE has been set up without direct, timely levers to secure the public health outcomes the Department expects, so PHE provides tools and data, support and advice to help local authorities to meet public health objectives. Its ability to influence and support public health outcomes will be tested in future should the grant cease to be ring-fenced. In parts of the system, local authority spending is not fully aligned to areas of concern. There is a difficult balance between localism and PHE's accountability for improving outcomes, and it is too early to conclude yet on whether PHE's support is delivering value for money.

Recommendations

20 The following recommendations are designed to help the Department of Health and PHE to support local authorities in delivering economic and effective public health outcomes from the new arrangements.

a **PHE should review how it can best provide stronger support for public health staff in local authorities.** We found a number of areas where more support for local public health staff would be valuable. PHE should particularly seek to:

- improve the responsiveness of its knowledge and intelligence teams to local authority requests for support;
- help local authority teams build up their own knowledge and evidence skills;
- act swiftly on the findings of PHE's strategic review to further strengthen how PHE operates;
- improve advice to local authorities on their support to clinical commissioning groups; and
- help local authority teams understand the evidence base and cost implications of different public health interventions, including sharing best practice.

b **PHE should continue to improve the tools and information available to support and influence local authorities, and make best use of these itself.** PHE has not yet systematically reviewed spending and outcomes data so it can provide support where it is most needed. PHE should work with local authorities to improve the accuracy of budgeting and spending data. It should also continue to develop strong outcome measures.

c **PHE should consider if and how it would adapt its approach to influencing local authorities if and when the Department removes the ring-fence.** PHE is accountable for securing improved public health outcomes. It has limited levers to achieve these outcomes and therefore PHE's need to influence will potentially be even greater amid increased local authority autonomy over spending.

d **PHE should write a cross-Whitehall influencing strategy.** To date, PHE has engaged with government departments on different issues, but it has not documented a formal coordinated approach. PHE should identify the top priority organisations to influence, the actions to obtain maximum impact on those issues and the measures to review its success.

e **The Department and PHE should use the opportunity created by PHE's strategic review to codify PHE's role in speaking to the evidence and the Department's role in making policy.** The role of PHE is to assess and present evidence on public health issues, while the Department has a responsibility to develop policy. Both parties should ensure that the outcome of the strategic review supports this position, removes any potential overlap and provides clarity to stakeholders.

Part One

The new public health system

1.1 This Part introduces:

- what is public health and why it is important;
- responsibilities and funding in the new system; and
- the scope of our study.

What is public health?

1.2 Public health is about helping people to stay healthy, and protecting them from threats to their health. It encompasses several different aspects. Activities to improve health and reduce inequalities include tackling problems such as obesity, alcohol misuse and smoking. There are also activities to protect the public's health from infectious diseases and other hazards. Finally, some activities seek to improve sustainable health and care services.

1.3 Improving the public's health is important. The major causes of preventable illness and premature death are dominated by 'diseases of lifestyle', where smoking, alcohol misuse, drug misuse, high blood pressure, obesity, poor diet and insufficient exercise are contributing factors. For example, type 2 diabetes is strongly linked to obesity. Infectious diseases are also a persistent threat to health, with the emergence of new infections and the resurgence of old ones such as tuberculosis. Health inequalities between areas can be large, for example male healthy life expectancy in England ranges by area from 52.5 to 70 years. The social environment, behaviours and biological factors are all important influences on health. Improving health and wellbeing creates a more economically and socially active population. Previously, health funding focused much more on treatment than on the causes of poor health. But improving the population's health would help to reduce the burden on the NHS and the economy (**Figure 1** overleaf).

Figure 1
Examples of costs to the NHS of poor public health

Obesity	The Foresight Report in 2007 estimated that direct health care costs attributable to being overweight or obese were £4.2 billion, potentially rising to £6.3 billion in 2015.
Alcohol misuse	Estimates suggest alcohol-related harm costs the NHS in England £3.5 billion a year overall.
Smoking	Research in 2010 indicated that the cost to the NHS of treating diseases caused by smoking is approximately £2.7 billion a year.

Sources: Government Office for Science, *Foresight Report, Tackling Obesities: Future Choices – Project Report, 2nd Edition*, October 2007; Public Health England, *Alcohol Treatment in England 2012-13,* October 2013; C Callum, *Estimating the cost of smoking to the NHS in England and the impact of declining prevalence*, August 2010

Responsibilities in the new public health system

1.4 The implementation of the Health and Social Care Act 2012 made fundamental changes to the health system, including to public health services. Before this Act, the Department of Health (the Department) led on developing public health policy, but primary care trusts were responsible for improving public health locally. Expert agencies such as the Health Protection Agency and specialist health authorities led on specific national issues. The 2012 Act abolished primary care trusts as the main commissioners of health services (including public health). It also abolished the regional NHS strategic health authorities and the Health Protection Agency.

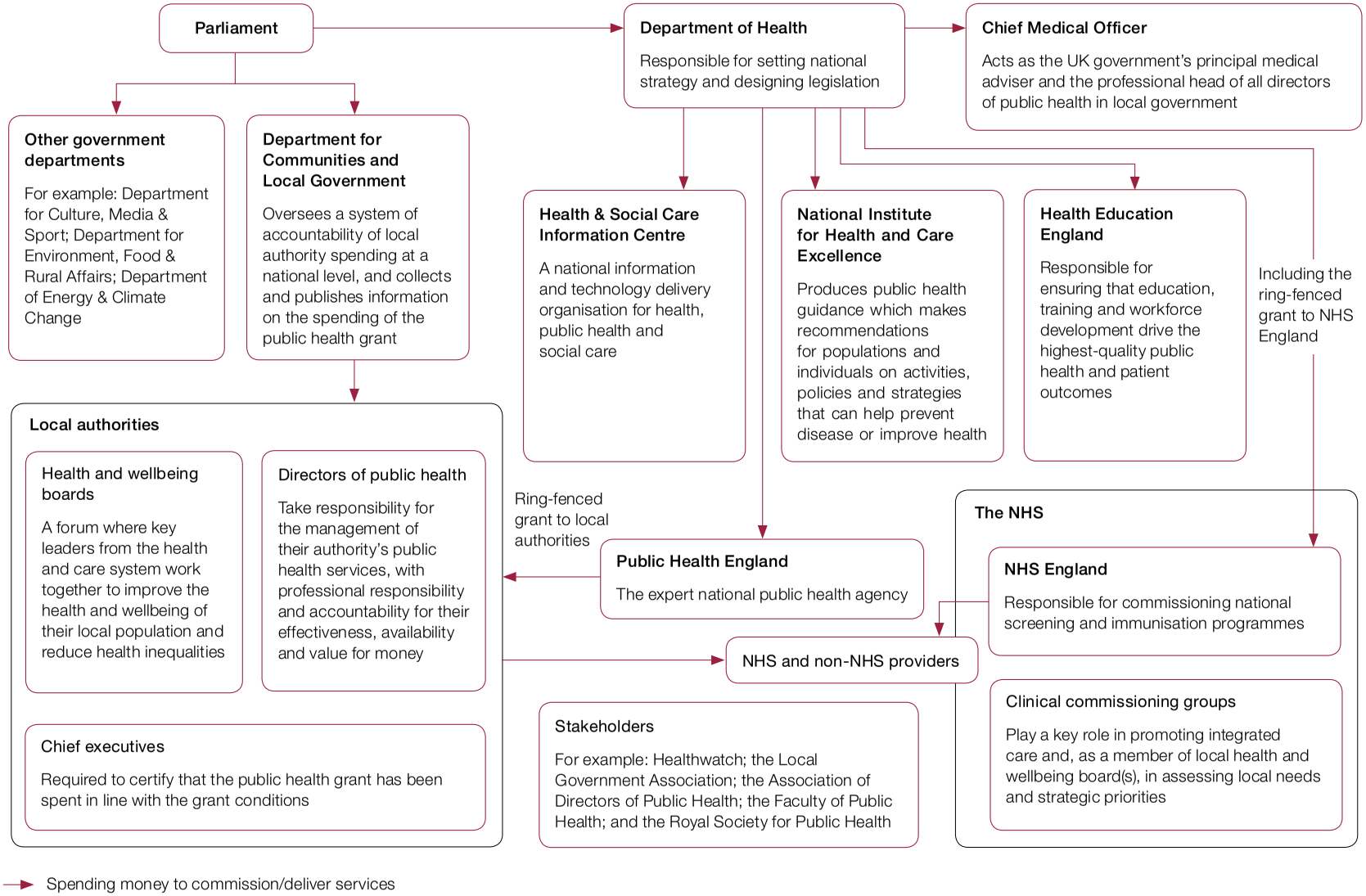
1.5 In the new system the Department continues to lead on national strategy and policy development, but responsibility for commissioning many local public health services has returned to local government (**Figure 2**). A new organisation called Public Health England (PHE) absorbed some of the Department's previous functions and those of many specialist agencies.[2] This organisation was established on 1 April 2013 as an executive agency of the Department. Finally, NHS England took on several responsibilities including commissioning some national screening and immunisation programmes and children's public health services (from pregnancy to age 5).

2 Staff were transferred to PHE from more than 100 other organisations, including from the Department and the Health Protection Agency.

Figure 2

Roles in the public health system from April 2013

Several bodies have roles in the new public health system



Source: National Audit Office

1.6 Local authorities now have a statutory duty to improve the health of their populations. From 1 April 2013 local authorities assumed responsibility for a large range of public health services including, for example, services to tackle drug or alcohol misuse. These services may be provided by commissioning services, for example through contracts with NHS providers. The Department prescribed 6 services that all local authorities must provide (**Figure 3**). These are not necessarily the priority public health issues in each area. Instead, the Department has prescribed them to, for example, ensure the service is consistent across local authorities or because the Secretary of State for Health has a legal duty to provide it. Each of the 152 single and upper tier authorities taking over public health responsibilities had to employ a specialist director of public health.[3] The director of public health has a number of statutory duties including:

- improving the health of the people in their area; and
- planning for, and responding to, emergencies that present a risk to public health.

The director of public health is jointly appointed by the local authority and the Secretary of State and should be a statutory member of the local authority health and wellbeing board.[4] Taking account of local priorities, the health and wellbeing board conducts a local needs assessment to produce a health and wellbeing strategy. This strategy should form the basis of local spending.

PHE's role

1.7 PHE's roles are to fulfil the Secretary of State for Health's statutory duty to protect health and address inequalities and to promote the health and wellbeing of people in England. PHE has operational autonomy and sets out to be the expert national public health agency. The remit letter from the Department describes the role PHE should play in the new system, based around 4 core functions (**Figure 4**).[5]

1.8 PHE provides a wide range of central services across England. These include specialist health protection, public health surveillance, epidemiology and microbiology services, and health improvement social marketing campaigns such as Change4Life. It employs more than 2,700 staff for health protection and microbiology activities alone.[6] In addition to its directly managed work programmes, PHE is the "national spine" for the public's health, linking local public health systems and national action.[7] PHE supports local authorities in their spending on public health. It has established 15 local centres supported by 4 regions to support and influence local authorities to get better public health outcomes.

3 Many parts of England have two tiers of local government: county councils (upper tier) and district, borough or city councils. In some parts of the country, there is just one (single) tier of local government providing all local services.
4 The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve health and wellbeing and reduce health inequalities. Each single and upper tier authority has a health and wellbeing board.
5 Department of Health, *Public Health England remit letter: 2014 to 2015*, June 2014.
6 Public Health England, *Who we are and what we do: our business plan for 2014 to 2015*, June 2014.
7 See footnote 6.

Figure 3
Public health spending categories

Prescribed functions

1 Sexual health services – sexually transmitted infections testing and treatment.

2 Sexual health services – contraception.

3 NHS Health Check programme.

4 Local authority role in health protection.

5 Public health advice.

6 National child measurement programme.

Non-prescribed functions

7 Sexual health services – advice, prevention and promotion.

8 Obesity – adults.

9 Obesity – children.

10 Physical activity – adults.

11 Physical activity – children.

12 Drug misuse – adults.

13 Alcohol misuse – adults.

14 Substance misuse (drugs and alcohol) – youth services.

15 Stop smoking services and interventions.

16 Wider tobacco control.

17 Children 5–19 public health programmes.

18 Miscellaneous.

Source: Department of Health, *Local authority circular: public health ring-fenced grant conditions 2013-14,* January 2013

Figure 4
Public Health England's core functions

PHE's core functions are set out in its business plan and remit letter

Protecting the public's health from infectious diseases and other hazards to health

Involves PHE working with key partners as well as providing the national infrastructure for health protection.

Improving the public's health and wellbeing and reducing health inequalities

Achieved through PHE's own actions and by supporting government, local authorities and the NHS to secure gains through evidence-based interventions.

Improving population health through sustainable health and care services[1]

Includes PHE providing advice to NHS England and promoting the evidence of the return on investment of public health interventions.

Building the capability and capacity of the public health system

Includes PHE supporting and developing a skilled public health workforce capable of meeting the challenges to the public's health.

Note

1 This function is also sometimes called healthcare public health.

Sources: Department of Health, *Public Health England remit letter: 2014 to 2015*, June 2014; Public Health England, *Who we are and what we do: our business plan for 2014 to 2015*, June 2014

1.9 The Department's remit letter holds PHE to account for making progress in improving outcomes in the public's health. PHE is responsible for obtaining and publishing data on outcomes at least annually against a public health outcomes framework created by the Department. Publishing such data exposes variations in performance and promotes accountability.

Funding in the new system

1.10 In 2013-14 the Department separated out funding for public health for the first time. It allocated a total of £5.8 billion as follows:

- PHE received £3.6 billion – of this, it provided £2.7 billion as a ring-fenced grant to all 152 single and upper tier local authorities to fulfil their duty to improve the public's health;
- NHS England received a ring-fenced grant of £1.8 billion for its public health activities, plus a further £0.4 billion for services provided through primary care; and
- organisations such as Health Education England, the Health & Social Care Information Centre, and the National Institute for Health and Care Excellence (NICE) also received funding from the Department – these bodies carry out some public health functions.

For 2014-15, the Department allocated £5.9 billion for public health, comprising: £3.6 billion to PHE, of which £2.8 billion was the grant to local authorities; and £2.3 billion to NHS England, of which £1.9 billion is ring-fenced.

Scope of the study

1.11 Given that the new arrangements have only been in place since April 2013, it is too early to assess value for money of the whole public health system. Instead, in this report we review PHE's arrangements for the £2.7 billion ring-fenced grant funding to 152 local authorities. We examine whether these arrangements are likely to lead to good value for money from the public health grant. In this report we do not assess local authority provision of public health services. Our focus is on PHE's role in supporting local authorities to deliver value for money. We do not assess PHE's centrally managed programmes for health protection and health improvement, nor do we evaluate NHS England's public health activities.

1.12 We set out our findings as follows:

- Part Two sets out analysis of local authority grant budgets and spending, and early information on the results so far;
- Part Three examines the governance and accountability arrangements over the ring-fenced grant to local authorities; and
- Part Four examines how PHE seeks to maximise the effectiveness of the new public health grant through its support and advice.

1.13 Our examination included a survey of directors of public health, visits to 4 local authorities, interviews and document reviews. We describe our audit approach and evidence base in Appendices One and Two.

Part Two

Local authority public health spending

2.1 This Part examines:

- funding allocations to local authorities;
- spending decisions by local authorities; and
- what Public Health England (PHE) has achieved so far.

Variation in public health needs

2.2 Across England the health of the population varies greatly. Healthy life expectancy for men ranges from 52.5 years in Tower Hamlets to 70.0 years in Richmond upon Thames; for females it ranges from 55.5 years in Manchester to 71.0 years in Wokingham.[8] There is also variation in the factors that contribute to this healthy life expectancy, for example:

- the proportion of obese or overweight adults ranges from 46% in Kensington and Chelsea to 74% in Doncaster;
- the proportion of adults who smoke ranges from 10.5% in Wokingham to 29.4% in Kingston upon Hull; and
- the number of alcohol-related admissions to hospital ranges from 365 per 100,000 people in Wokingham to 1,121 in Blackpool.[9]

8 Healthy life expectancy is the average number of years that a person can expect to live in 'full health'.
9 These examples are taken from the public health outcomes framework data as at November 2014.

Funding allocations to local authorities

2.3 The Department of Health (the Department) is responsible for allocating healthcare funding, including funding for public health. Previously, primary care trusts received a single funding allocation to provide health and public health services. Under the new system local authorities receive separate funding for public health, which increases transparency. In setting the total amount of the public health grant for 2013-14, the Department did not assess the overall funding needed to achieve agreed outcomes. Instead, it started from a detailed baseline exercise to establish what primary care trusts had chosen to spend on public health before the transition. It then increased this baseline amount by 5.5%, indicating the importance it attaches to public health. The Department increased the grant by a further 5.0% in 2014-15. The baseline exercise was the first time the Department had estimated spending on public health in this way. The exercise revealed significant variation in what local primary care trusts had chosen to spend on public health previously.

2.4 Public health inequalities mean that local authorities will need different levels of funding for public health. The limited total funding must be allocated according to need if the Department is to maximise outcomes. In our recent report *Funding healthcare: Making allocations to local areas*, we described how the Department set out the proportion of public health funding that each local authority should receive.[10] It used a formula based on area population and an adjustment for relative health needs. It then increased individual authorities' baseline amounts by a minimum of 2.8% and a maximum of 10%. This ensured an above-inflation increase for every local authority and brought them closer to their target allocations.[11] A similar approach was taken in 2014-15.

2.5 For 2015-16, the Department will maintain 2014-15 grant values in cash terms to promote stability. Until target allocations are reached many authorities will receive more or less than their funding share as dictated by the needs-based formula. In 2013-14, 51 of 152 local authorities were more than 20% from their target allocation; in 2014-15 and 2015-16 this had reduced to 41 local authorities (**Figure 5** overleaf).

2.6 The complex process of calculating original baseline spending was largely a success, with only minor errors in allocating spending between local authorities and the NHS. For 2013-14 and 2014-15, more than 1 in 5 local authorities negotiated temporary transfers to better align funding with service delivery. The Department, NHS England and PHE have collected data on where such locally agreed transfers have taken place. An annual amount of £17.0 million was transferred into 22 local authorities, and £9.1 million was transferred to the NHS from a total of 19 authorities.[12] The net adjustments represent just 0.3% of the public health grant, although for 3 authorities the net transfers represent more than 10% of their public health allocation. All adjustments will be reflected within the 2015-16 allocations.

10 Comptroller and Auditor General, *Funding healthcare: Making allocations to local areas*, Session 2014-15, HC 625, National Audit Office, September 2014.

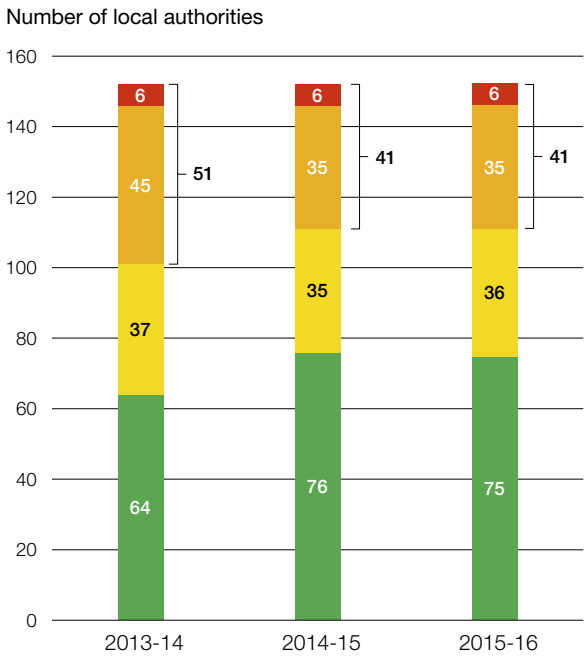
11 There was one exception: one local authority received only 2.2% growth due to an adjustment for historical performance.

12 These data are provisional as final figures for Essex and Thurrock have not yet been agreed. A number of local authorities agreed transfers to and from the NHS. The figures exclude £0.2 million transferred from local authorities to other health bodies.

Figure 5

Public health grant allocations: distance from target

In 2015-16, 41 local authorities will be more than 20% from their target allocation, down from 51 in 2013-14



Note

1 Data for 2015-16 are provisional as final grant values for Essex and Thurrock have not yet been agreed.

Source: National Audit Office analysis of Department of Health data

Variation in local authority spending

2.7 Local authorities must provide 6 prescribed public health functions (Figure 3). Otherwise, they have a large degree of freedom in how they spend their public health grant. This freedom enables them to tackle the public health issues they see as most important. Each health and wellbeing board is required to publish information about the area's health needs in a needs assessment. They translate these needs into priorities for local services via a health and wellbeing strategy.

2.8 Local authorities allocate public health spending across 18 categories in their budgeting and spending reports to the Department for Communities and Local Government, aiding comparison between areas (Figure 3). Budgeting and spending data show significant variation in how local authorities have allocated spending across these categories (**Figure 6** overleaf). This variation may reflect different needs and priorities.

Aligning spending to needs

2.9 Spending of the public health grant in 2013-14 largely reflected the services that were commissioned before the transition. It takes time to reconfigure services, so refining the profile of local authority spending according to changes in priorities identified through local needs assessments will be a gradual process. In our survey, directors of public health told us that pre-existing contracts inherited from the primary care trust were still the number one influence on 2014-15 spending plans for 38% of the local authorities they covered.

2.10 Spending on public health is becoming increasingly aligned to local needs. Directors of public health generally reported that spending plans in 2014-15 were more influenced by local authority needs and priorities than in 2013-14 (**Figure 7** on page 23). Our analysis of 2014-15 budgets shows a gradual shift in spending profiles. For example, in 2013-14 local authorities had budgeted 54.3% of spending on sexual health, drugs and alcohol services; in 2014-15 this proportion had reduced to 52.8%. The directors of public health who responded to our survey felt that the grant was spent in the most efficient and effective way in nearly 4 out of 5 local authorities.

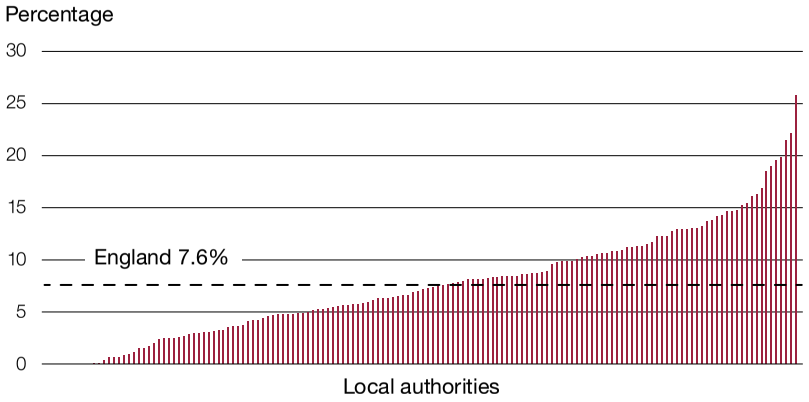
2.11 PHE has produced an online tool that allows local authorities to compare relative budgets on public health categories in 2013-14 to relative outcomes achieved. For several categories of public health spending such as smoking, some local authorities have relatively poorer outcomes, but relatively smaller budgets devoted to tackling these problems. This suggests there are some areas where spending may not yet be fully aligned to the greatest needs. There are various potential factors that might explain these decisions, such as the need for local authorities to balance spending on a number of worsening outcomes, pressing needs, or decisions about which are the most cost-effective interventions.

Figure 6

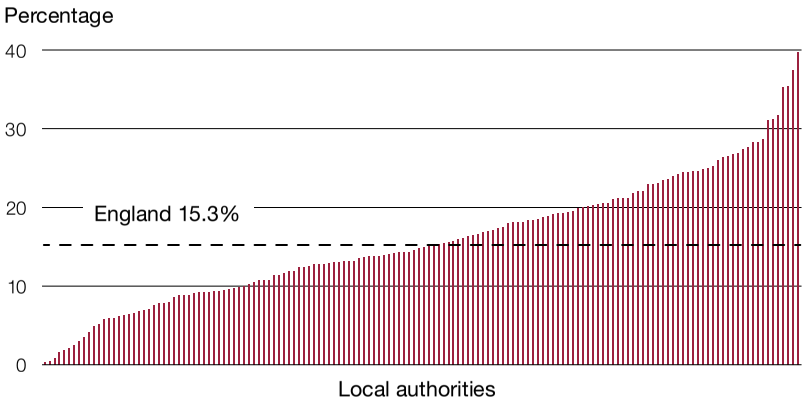
Proportion of public health spending on selected categories, by local authority 2013-14

There is considerable variation in the proportion spent by local authorities on each category

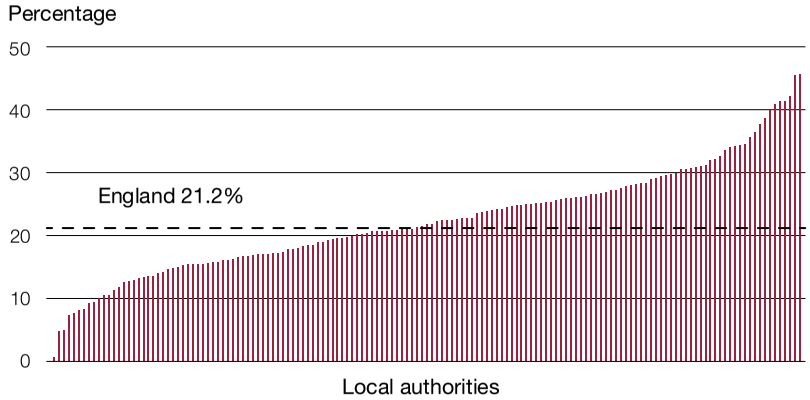
Alcohol – adults



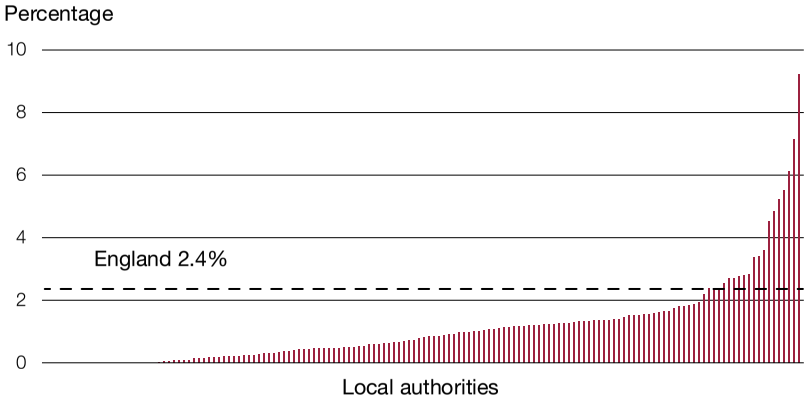
Sexually transmitted infections testing and treatment



Drug misuse – adults



Obesity – adults



Note

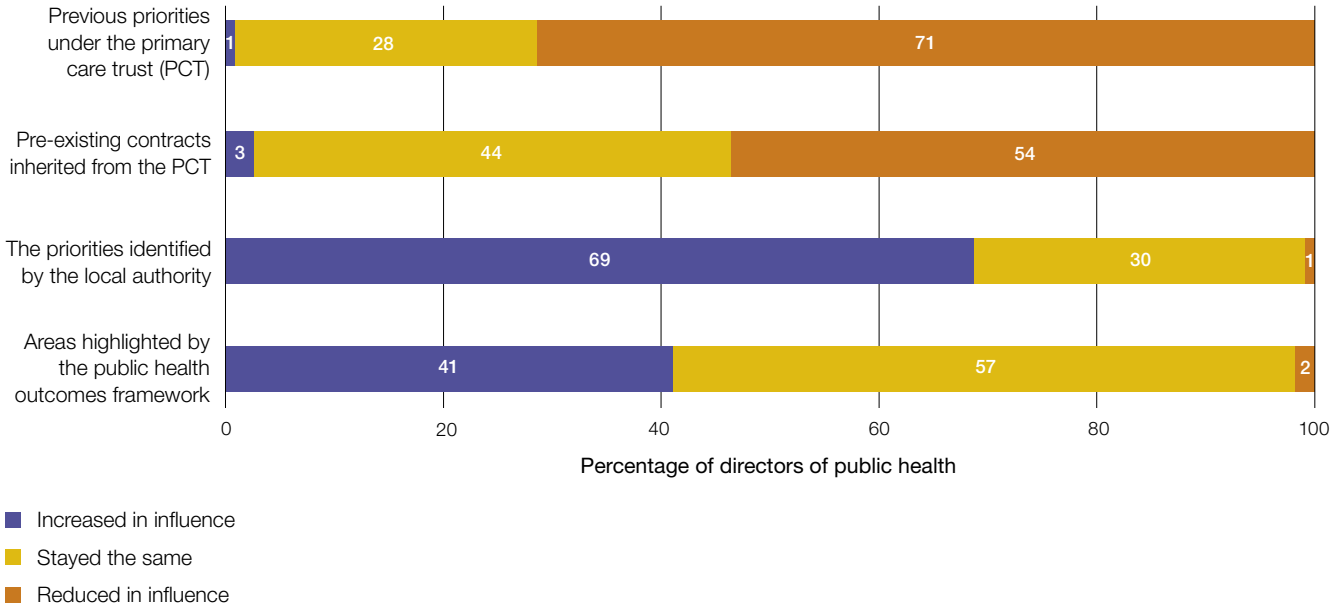
1 Net current expenditure, which excludes capital and non-grant income.

Source: Final outturn data 2013-14 – Department for Communities and Local Government

Figure 7

Change in influence on public health spending plans, 2013-14 to 2014-15, as reported by directors of public health

The influence of local authority priorities increased between 2013-14 and 2014-15



Notes

1 Responses covered 112 local authorities.

2 Percentages may not sum to 100 due to rounding.

Source: National Audit Office survey of directors of public health

2.12 We analysed spending data by comparing actual spending on specific categories in 2013-14 with relative changes in outcomes. This highlighted some areas where spending may not be being targeted to where outcomes are worsening. For example, between 2010-11 and 2012-13 alcohol-related admissions to hospital increased by more than 6% in 26 local authorities. These 26 local authorities spent on average 6% of their public health spending on alcohol services for adults. This was significantly less than the 9% spent by the 26 local authorities where alcohol-related admissions reduced the most. Further analysis is needed to understand such variations.

Financial pressures on spending

2.13 The Department created a ring-fenced grant to protect investment in public health and ensure local authorities could meet their new public health responsibilities. This ring-fence was initially set up for 2 years, though it has now been extended to a third year (2015-16). The Department has not decided whether or not the ring-fence will remain in future years. The ring-fenced funding was intended to pay for services previously provided by primary care trusts. Local authorities also chose to deliver other services that have an impact on public health, such as leisure, housing, education and social care, from the local government funding settlement.

2.14 Placing public health within local government can bring service efficiencies through greater integration, for example with social care services. During our visits to local authorities we saw examples of other local authority services such as environmental protection and housing considering public health issues. Almost two-thirds of directors of public health who responded to our survey had been consulted on how wider council spending could support public health outcomes.

2.15 There has been strong support for transferring responsibility for public health to local authorities, but continued local government spending cuts may impact on the total amount spent on public health. As calculated for our recent report *Financial sustainability of local authorities*, government funding for local authorities has fallen by 28% in real terms over the 2010 Spending Review period.[13] Using illustrative data from the Department for Communities and Local Government, this reduction will reach 37% by 2015-16.[14] The pressure on public health services could increase if the ring-fence is removed. Some directors of public health talk about the pressure to use parts of the public health ring-fenced grant to fund existing public health services previously funded from other government funding, for example domestic violence support services. Local authorities are free to do this if they wish, provided that their spending and activity meet both their public health and other responsibilities. But the effect may be to reduce total public health spending.

13 Comptroller and Auditor General, *Financial sustainability of local authorities 2014*, Session 2014-15, HC 783, National Audit Office, November 2014.

14 These changes in government funding have been calculated using a chain-linked index that excludes the public health grant and Better Care Fund. More details about this methodology can be found here: www.nao.org.uk/report/financial-sustainability-of-local-authorities-2014/

Early achievements

2.16 PHE was established in April 2013 and public health responsibilities transferred from primary care trusts to local authorities. During this transition time, delivery of public health services continued. In its 2013-14 annual report, PHE describes a number of ways it has helped local authorities in their public health roles (**Figure 8**). For example, it provided leadership to the NHS Health Check programme, which provided health checks to 10% more people in 2013-14 than in 2012-13. Given the long lead time in improving public health, at this stage most of PHE's achievements relate to particular projects or activities, rather than visible outcomes. There is, however, evidence of short-term gains in a number of public health interventions that could translate into long-term outcomes. For example, the number of people successfully completing alcohol treatment increased by 6% between 2012-13 and 2013-14.[15]

Figure 8
Public Health England's achievements in 2013-14

In its first annual report, PHE reports a range of achievements in supporting local authorities

Drug recovery

PHE prioritised 54 local authority areas for intensive diagnostic and support work to improve recovery and reduce relapse rates. There has been a 1.3% increase in recovery rates in these local authorities receiving targeted support.

Alcohol

PHE supported the Home Office programme to establish 18 local alcohol action areas in England that will explore new ways of tackling alcohol-related harm.

Evidence and guidance

PHE published summaries of evidence to help local areas improve outcomes in chlamydia, HIV, obesity and mental wellbeing. It provided guidance and IT tools to local authorities on the National Child Measurement Programme.

NHS Health Checks

PHE provided leadership and support to this programme, which is now delivered in every local authority in England. More than 2.8 million people were offered an NHS Health Check in 2013-14, with 49% taking up the offer.

Health protection

PHE worked alongside local authorities, the Environment Agency and the emergency services to provide expert advice during the floods and storms in winter 2013-14.

Outcomes data

PHE developed tools to improve access to data. These included an online tool to analyse public health outcomes data, a tool that presents data on the causes of premature mortality (Longer Lives) and local authority and neighbourhood health profiles.

Source: Public Health England, *Annual Report and Accounts 2013-14,* June 2014

15 Public Health England, *Adult Alcohol statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2013 to 31 March 2014*, October 2014.

Part Three

Assurance and accountability for the grant to local authorities

3.1 This Part examines:

- roles and accountability of key bodies;
- assurance over the proper spending of the grant to local authorities;
- levers to ensure the grant delivers public health outcomes and value for money; and
- how the Department of Health (the Department) holds Public Health England (PHE) to account for its performance.

Accountability structures

3.2 Responsibilities and accountabilities in the new public health system are set out across several different documents (**Figure 9**). The Department has overall accountability for the health system. PHE is accountable to the Department for use of its allocated funding and progress towards public health outcomes. In turn, local authorities are accountable to PHE for the appropriate use of the public health grant, but to their electorates for delivering outcomes. The next sections set out:

- how PHE gets assurance on proper use of the public health grant to local authorities; and
- how PHE promotes value for money and good public health outcomes.

Figure 9
Key accountabilities for public health

Responsibilities and accountabilities in the new public health system are set out across several different documents

Department of Health

"Secretary of State is accountable to Parliament for the health system.

Sets the public health outcomes framework and incentivises the achievement of certain national priorities through the health premium.

If a failure should occur related to delegated public health functions, the Secretary of State can make regulations to require local authorities to take certain steps, and he can require the local authority to review the performance of the director of public health.

Setting national priorities and monitoring the whole system's performance to ensure it delivers what patients, people who use services and the wider public need and value most."

Local authorities

"Primarily accountable to their electorates, within a system of accountability that is overseen at national level by the Department for Communities and Local Government.

Additional accountability arrangements for the money that… [the Department of Health] allocates to local authorities for public health.

Required to have regard to the public health outcomes framework.

The director of public health is also required to produce an annual report on the health of the local population, which the local authority will be required to publish, and which provides an accountability mechanism both locally and to… [the Department of Health].

Accountable to PHE's chief executive as PHE's Accounting Officer for the use of the resources granted to them by PHE.

The chief executive of each local authority is required to certify that the public health grant has been spent in line with the grant conditions."

Public Health England

"A framework agreement that sets out its relationship with the Department, and the Department holds it to account for its performance.

The agency's chief executive is its Accounting Officer; the Accounting Officer is accountable to… [the Department] and to the Secretary of State for the proper use of public funds allocated to PHE.

Discharging its statutory functions and delivering its objectives set out in the business plan.

Expert national public health agency.

The Department will assess the strength of PHE's relationship with its key partners on a regular basis.

The government looks to PHE to make real progress in improving outcomes… and will hold it to account for doing so.

PHE will be expected to continue to report transparently on health outcomes and on progress across the public health outcomes framework.

Has operational autonomy.

Enable the system to be held to account for its performance, for example by publishing public health outcomes data and exposing variation in performance.

If PHE identifies any issues of concern, the Secretary of State reserves the right to independently audit the return.

PHE is responsible for the delivery of its objectives and… [the Department] will limit the circumstances in which it will intervene in its activities."

Sources: Department of Health, *Accounting Officer system statement*, October 2014; Department of Health, *PHE remit letter: 2014 to 2015*, June 2014; Public Health England, *Who we are and what we do: our business plan for 2014 to 2015*, June 2014; Public Health England, *Framework agreement between the Department of Health and Public Health England*, November 2013

Gaining assurance on proper use of the public health grant

3.3 In 2013-14 PHE used a variety of methods to gain assurance over spending by local authorities and compliance with grant conditions (**Figure 10**). There are grant conditions aimed at ensuring local authorities comply with public health duties, and 6 prescribed services (paragraph 1.6) that local authorities must provide. The conditions do not dictate the amount that local authorities must spend on each category. During the year PHE has continued to review its assurance measures. In May 2014 all local authorities sent provisional confirmation that they had complied with grant conditions for their 2013-14 spending. In August 2014 PHE added a requirement for directors of public health to also sign the final assurance statements as well as the senior responsible officers and received responses from all local authorities.

Figure 10

Public Health England's sources of assurance on the public health grant and value for money

There are several sources of assurance on the public health grant

Local authority spending returns submitted to the Department for Communities and Local Government

Budgeted spending returns:

- Spending split into 18 categories of public health activity.

Quarterly outturn returns:

- Spending split between prescribed and non-prescribed categories.

Annual spending returns:

- Spending split into 18 categories of public health activity.
- The authority's chief executive or section 151 officer certifies the return to say the grant has been used for the purposes intended.

Director of public health annual reports

Directors of public health have a statutory duty to produce an annual report and local authorities have a duty to publish it.

Statements of assurance from local authorities

- Local authorities confirm that the grant has been spent in line with its conditions.
- Local authority chief executives or section 151 officers provided preliminary statements in May 2014.
- Directors of public health also sign off the final year-end statements.

Public health outcomes framework

- Public Health England publishes data on national and local delivery.

Other assurance methods

Including:

- Member-led scrutiny in local government.
- Sector-led improvement and benchmarking.
- Local authority internal and external audit.
- Department for Communities and Local Government governance.

Source: Public Health England's map of assurance

3.4 In line with standard local authority financial reporting, PHE does not receive provisional spending data at a topic level (including prescribed functions) until 5 months after year-end. This restricts the timing of PHE's analysis of spending, to see where its support may be best directed. In addition, the provisional budgeting and spending data for 2013-14 has highlighted early problems with data accuracy. Provisional spending reports showed that for each of the 6 prescribed public health spending categories, some local authorities recorded nil spending. In total, 81 local authorities initially recorded nil spending against at least 1 prescribed function. PHE did not thoroughly investigate these data problems when budgeting data showing similar patterns were released in July 2013.

3.5 PHE and the Department for Communities and Local Government worked with local authorities to improve the quality of these data, so that final spending data accurately reflects the activity which has taken place during the year. PHE told us that it will update the grant conditions for next year to specifically highlight that spending must be accurately shown against each category and will produce guidance to share best practice. Accurate data are important for ensuring transparency, and therefore enabling effective local accountability. It is also necessary for PHE to provide high-quality analysis tools for local government, and to effectively direct its support.

Levers to promote good public health outcomes and value for money

3.6 The new public health system makes local authorities responsible for their own public health spending. Local councillors decide what represents value for money locally, and they are accountable to their local electorate for delivering the outcomes. There are a range of checks and systems in place to give assurance on spending, including sector-led improvement and member-led scrutiny. At a national level the Department for Communities and Local Government oversees this system of accountability. Our recent report on grant funding to local authorities found that "the Department [for Communities and Local Government] believes that the system creates the conditions for local authorities to achieve value for money… However, the Department's monitoring information gives limited insight into whether this is happening in practice."[16]

3.7 PHE has been set up with two formal levers through which it can seek to influence local authorities on public health outcomes and value for money. These are the public health outcomes framework and the health premium, covered in more depth in the next section.

16 Comptroller and Auditor General, *Local government funding: Assurance to Parliament*, Session 2014-15, HC 174, National Audit Office, June 2014.

The public health outcomes framework

3.8 In 2012 the Department created a framework of outcome measures to show progress in public health, both nationally and locally, in the longer term. The public health outcomes framework sets out a broad range of indicators for improving and protecting health. PHE is responsible for obtaining and publishing data for this framework, which includes 196 different measures across 68 indicators.

3.9 The outcomes framework has brought together disparate datasets on public health, and created indicators where no comparable information existed; this increases transparency and accountability. In our survey, 83% of directors of public health reported that they used the framework frequently. But time lags in obtaining and updating indicators limit its usefulness as a short-term tool for evaluating the impact of recent spending. More than one-third of directors of public health (36%) rated the timeliness of data published by PHE as poor. Of the 196 framework measures, 112 have a time lag of 18 months or more; no data are available yet for a further 21 measures. The lack of trend data for some indicators has limited their use, though this is improving with time.

3.10 Local authorities must be able to report back to their electorates on progress on the public health indicators that best reflect their local needs and priorities. Collecting annual data on public health outcomes aims to incentivise local authorities by providing the comparisons they need to assess their own performance. In line with the system's design, the adequacy of this assurance will depend on the extent of scrutiny and challenge provided by local stakeholders.

The health premium scheme

3.11 A public health premium incentive scheme will be phased in from 2015-16 to reward local authorities for progress against a subset of indicators from the public health outcomes framework. **Figure 11** sets out more details of the scheme. The Department chose to introduce the scheme from 2015-16 so that payments would reward local authority activity, not results arising from previous spending decisions. However, it did not release details of the scheme until September 2014. This timing may limit how effective the premium is in providing an incentive to get results for the first year, as local authorities could not factor it into their plans.

3.12 The total premium to be distributed across local authorities for the trial year in 2015-16 will be £5 million. This amount is less than 0.2% of the total ring-fenced grant for 2015-16. Therefore it is likely to have a limited impact in influencing local spending decisions. Also, giving local authorities the choice of a second indicator may incentivise them to select the local indicator that they believe they are most likely to show improvement in, which may not be the same as their top local priority.

Figure 11
Health premium incentive scheme

In 2015-16 an incentive payment of £5 million will be shared between those local authorities that show sufficient progress on 2 public health indicators

Indicators:

- **National indicator** – 'Successful completion of drugs treatment' using combined outcomes framework data for opiate and non-opiate users; and
- **Local indicator** – Selected by local authorities from a list of approved indicators.

For each measure, where a local authority can demonstrate improvement by the end of March 2015 it will receive a share of the £5 million incentive, proportional to its target allocation.

The Department expects to roll this scheme out in the next few years. It will expand the number of indicators and try to accommodate locally developed health inequalities indicators.

Note

1 Scheme details proposed during consultation in September 2014.

Source: Department of Health and Public Health England, *Health Premium Incentive Scheme 2014/15* and *Public Health Allocations: a Technical Consultation*, September 2014

How the Department holds PHE to account

3.13 PHE has developed a scorecard so it can give assurance to the Department about public health outcomes and monitor its own performance. The 2014-15 scorecard tracks 97 indicators across a range of outcomes and projects aligned to PHE's business plan and its internal operations. This includes key outcomes of the public health grant to local authorities and projects to support local authorities in their role. The scorecard clearly focuses on PHE's objectives as stated in its remit letter from the Department, giving a balanced view of most significant areas of work.

3.14 The scorecard forms the basis of quarterly assurance meetings where the Department challenges and supports PHE through discussions on progress and necessary action. Our review of the minutes found that in a small number of cases, indicators rated red or amber-red (indicating cause for concern) on the scorecard were not discussed at these meetings, although PHE told us these were discussed in alternative forums.[17]

3.15 The scorecard does not assess PHE's role in supporting and providing constructive challenge to central government. On topics such as improving blood pressure and reducing sugar consumption, PHE seeks to influence stakeholders across government, not just those within the health service. But scorecard indicators, and the business plan milestones that support these, do not assess the influence PHE has on local government and on Whitehall to maximise its impact on these topics. Instead, the Department relies on discussions outside of the formal accountability process to assess effectiveness in this area.

17 The scorecard uses the 'traffic light' system of red, amber and green ratings for indicators, where green indicates on track and red indicates there is a cause for concern.

Part Four

Maximising impact through leadership, support and influence

4.1 This Part assesses:

- Public Health England's (PHE's) support and advice to local authorities;
- its liaison with stakeholders and system leadership; and
- structures and capacity within the system to carry out these roles effectively.

Supporting and advising local authorities

Supporting local authorities

4.2 As local authorities are responsible for their own spending and PHE has limited formal levers (Part Three), PHE must focus on supporting and advising local authorities to secure public health outcomes. PHE has tried to establish strong working relationships with local authorities right from the outset, for example through senior-level visits and discussions.

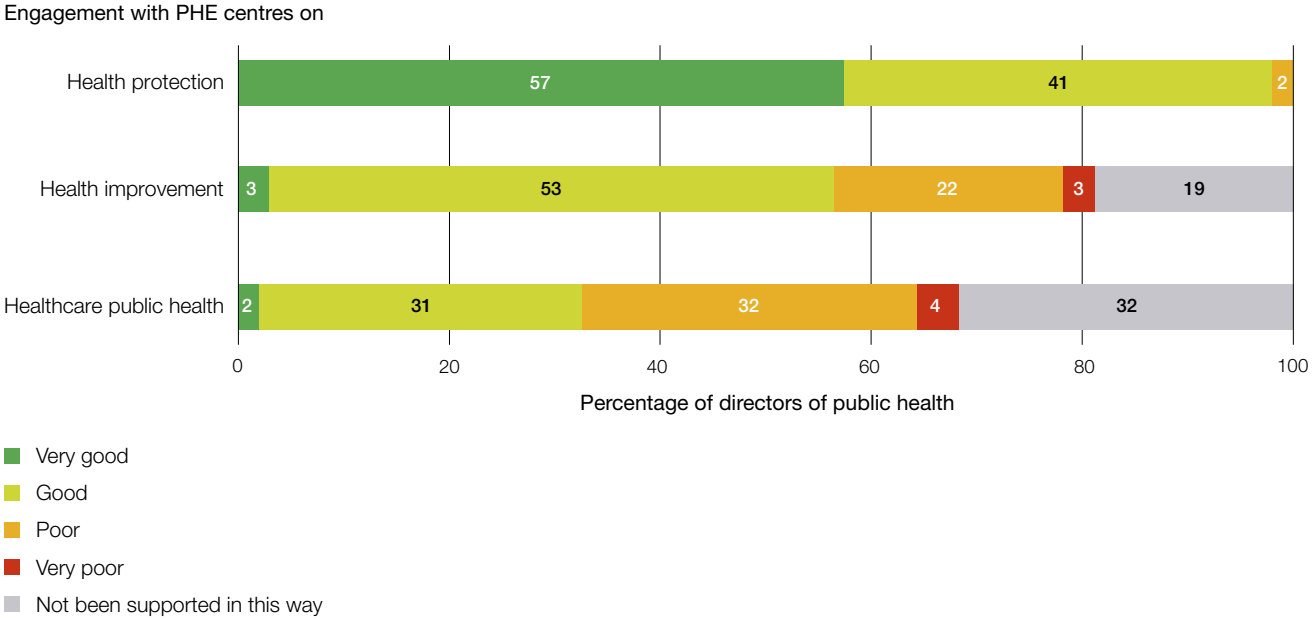
4.3 PHE's main mechanism for supporting local authorities is through locally based centres.[18] These centres provide health protection and emergency response services, and support in improving health and wellbeing. In a survey of PHE's stakeholders, 75% of local authority stakeholders reported they had a very or fairly good working relationship with PHE.[19] However, our survey showed that directors of public health had mixed views on the support functions of the centres. Of those who responded, 98% rated engagement with PHE centres on health protection as good or very good compared with 56% for health improvement (19% reported they had not been supported on health improvement) (**Figure 12**). Some centres cited lack of capacity as impacting on the support they have been able to provide. PHE reported a 13% vacancy rate among centre and region staff as at August 2014.

18 There are 14 centres managed through 3 regions, plus London which acts as a centre and a region combined.
19 Ipsos MORI surveyed 299 stakeholders in January 2014, 174 of these worked in local authorities. Ipsos MORI and Public Health England, *Public Health England 2013/14 Stakeholder Survey*, February 2014.

Figure 12

Directors of public health's ratings of Public Health England's centres

Directors of public health rated support on health protection very highly, but had a mixed view of other aspects of support from PHE's centres



Notes

1 101 responses representing 112 local authorities.

2 Percentages may not sum to 100 due to rounding.

3 Healthcare public health is also known as 'improving population health through sustainable health and care services'.

Source: National Audit Office survey of directors of public health

4.4 Local authorities now have a duty to provide public health expertise and advice to their NHS clinical commissioning groups. PHE's role is to provide public health expertise and advice to NHS England, as well as supporting local authorities in their advisory role. Some centre directors told us that in particular local authorities were struggling with building relationships with their clinical commissioning groups. Our focus group with commissioners gave mixed views about how much input directors of public health had into public health advice to these clinical commissioning groups. In our survey about half of directors of public health who had been supported in this way reported that the support was poor (Figure 12). Thirty-two per cent reported that PHE had not supported them in this way.

4.5 PHE supports local authorities on the evidence base for public health interventions. It uses a network of 8 locally based knowledge and intelligence teams to produce tools and support on analysis and knowledge management to centres, local authorities and to the NHS. So far, these teams' main focus has been on producing national tools and reports with locally selectable data. For example, the Longer Lives tool provides data on premature mortality for every local authority. Another tool compares public health spending and outcomes, allowing local authorities to prioritise their spending. These tools have been well received. There are training courses to support them and intelligence networks to increase relevance and accessibility. More than 90% of the directors of public health who responded to our survey stated that they frequently or sometimes use the tools. PHE also provides regional reports that highlight areas of poorest outcomes using data from the public health outcomes framework.

4.6 There is a gap in expectations between the support local authorities want from the knowledge and intelligence teams, and the support they get. Nearly half of directors of public health (49%) felt the frequency of contact with their knowledge and intelligence team was poor or very poor and more than half (56%) felt that the knowledge and intelligence teams were not aligned to their own priorities and intelligence work. PHE told us that sector-wide difficulties in accessing and sharing data have limited analysis and insight for local authorities.

4.7 Local authorities need extra support to understand and quantify the relative impact of public health interventions. In our survey of directors of public health, 83% said that they use evidence produced by PHE on what works in public health at least to a moderate extent. Generally, there was positive feedback on the topics covered, ease of use and robustness (**Figure 13**). The majority of directors of public health (59%) reported that PHE had not supported them in interpreting the evidence base for public health. Local authorities told us that they particularly needed support in forecasting the financial impact of particular interventions. The National Institute for Health and Care Excellence has developed 3 return on investment models covering smoking, alcohol and physical activity interventions. PHE has established a workstream to support the use of these tools locally and to develop a broader range of tools to understand cost-effectiveness.

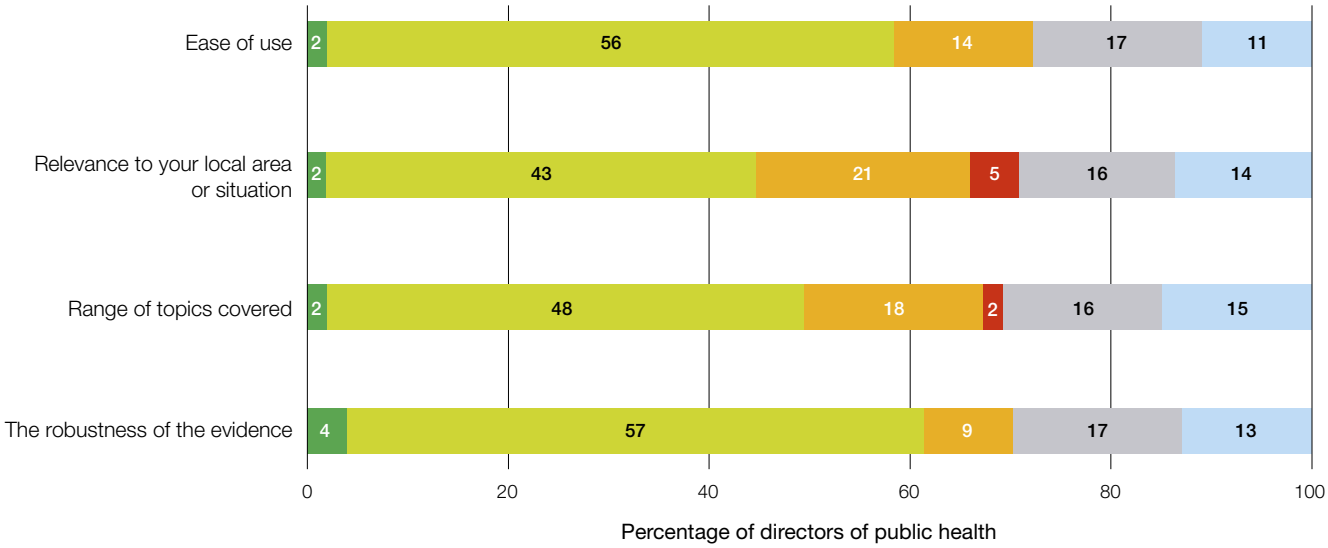
Advising local authorities

4.8 From its inception, PHE has had a considerable focus on advising and influencing local authorities in a range of ways. These include regular senior management visits to local authorities to discuss priorities and performance, tailored support from PHE centres and sharing advice on what works on specific topics. PHE has, with other stakeholders, recently agreed a joint sector-led approach on how to address the risk of underperformance by local authorities.

Figure 13

Directors of public health's ratings of Public Health England's evidence on public health interventions

There was a positive rating among those that had used the evidence



Notes

1 101 responses representing 112 local authorities.

2 Percentages may not sum to 100 due to rounding.

Source: National Audit Office survey of directors of public health

4.9 PHE needs clear and timely information on local authority spending and outcomes if it is to effectively advise local authorities in their efforts to improve the public's health. As described in paragraph 3.4, the financial data available are limited but, so far, PHE has not made best use of the data that do exist to inform its discussions. For example, it had not yet undertaken detailed analysis of budgeted spending compared with public health indicators, although it had recently developed a tool to do so. It will be particularly important to do so given continuing pressure on local authorities' overall budgets.

4.10 Close attention to outcomes data is also important if PHE is to gain early warning of any decline in public health outcomes and tailor its support to those local authorities that most need it. We saw examples of PHE's centres using data from the public health outcomes framework to identify potential areas of concern and target discussions with local authorities. For national topics we saw attempts to prioritise contact with local authorities. For example, in drug recovery, PHE targeted 54 local authorities for intensive support to improve outcomes. But there is no central formal structure for prioritising engagement with particular local authorities, although there are informal conversations to discuss any concerns. Such an informal approach makes it difficult for PHE to monitor the impact of its influencing. PHE has not yet set out how it might adapt its influencing approach in future if the ring-fence were to be removed. It will be particularly important to do so given continuing pressure on local authorities' overall budgets.

Liaising with others and PHE's system leadership

4.11 Working closely with stakeholders including the Department of Health (the Department), NHS England and other government departments will help PHE to support local authorities effectively. PHE has established itself at the centre of the public health system, communicating with key bodies and ensuring that partnership arrangements are working. It has recently published its priorities for public health in a document widely supported by stakeholders. In addition, the NHS 5-year forward view has a strong focus on public health. PHE has invested significant staff time in attending stakeholder meetings and in developing a national stakeholder engagement strategy that recognises the importance of these relationships. A survey of stakeholders found that "three-quarters of respondents have a good working relationship with PHE (76%) and only a fraction describe their working relationship as poor (3%)."[20]

20 Ipsos MORI and Public Health England, *Public Health England 2013/14 Stakeholder Survey*, February 2014.

4.12 Although collaboration with stakeholders is strong, there is sometimes confusion over who leads on improving the public's health. PHE's role is to be the expert public health agency, speaking for the public's health. However, the Department has retained responsibility for public health policy and has a substantial public health directorate. The National Institute for Health and Care Excellence issues evidence and guidance on a range of public health issues. The Chief Medical Officer produces an annual report on the public's health and opinions on public health issues such as sugar, alcohol pricing and e-cigarettes. This crowded arena makes it difficult for stakeholders such as local authorities to understand who leads on improving the public's health. PHE's strategic review identified a need to focus on PHE's role in assessing and presenting evidence on public health issues, and ensure it does not overlap with the Department's role as policy-makers.

4.13 Some stakeholders told us that they expected PHE to have a stronger system leadership on key public health issues affecting local authorities. Local authorities adopt their own approaches to tackling public health issues such as smoking, but they reported dissatisfaction with the level and speed of national support to complement their actions. Some stakeholders believe PHE should take a stronger lead on resolving local public health system issues, for example they highlighted difficulties in dealing with fragmented commissioning routes for some public health services. Some providers told us they had lost a significant proportion of their income due to teething difficulties with the new arrangements.

4.14 Wider government policies or initiatives such as those on housing, environment and education all influence the nation's health, so embedding public health into wider government is important. PHE's actions in influencing other government departments to consider public health issues will support local authority public health teams when they have similar discussions with their local authority colleagues. In a survey of its stakeholders, 92% felt advising national government on public health issues was a critical or very important function for PHE to perform.[21] Most felt it was performing this function well. PHE has, for example, engaged with Whitehall on the complex needs of troubled families. PHE contributes to a cross-government group set up on public health to discuss wider public health issues.

4.15 PHE's work on individual topics has considered the impact of other government departments too. To date, the individual ambitions of topic-led teams have not been drawn together into a coherent prioritised strategy for engaging across Whitehall. This raises a risk that a lack of clarity will dilute PHE's influencing efforts. In October 2014 PHE set out its top 7 priorities for public health. This prioritisation should help it develop its approach to influencing Whitehall.

21 Ipsos MORI and Public Health England, *Public Health England 2013/14 Stakeholder Survey*, February 2014.

Structure and capacity to deliver

4.16 Delivering better public health outcomes will depend on the structure and capacity of local authorities, and of PHE to support them.

PHE's structure and capacity

4.17 PHE's ability to support others is influenced by its own internal management and capacity. PHE has a clear senior management structure to oversee delivery of its responsibilities, supported by an organisational structure that includes directorates and thematic corporate programmes. But stakeholders reported a lack of visibility about who leads on some key roles and responsibilities. Transfers of public health staff have led to widespread variation in pay, often for the same job. PHE's first annual staff survey indicated dissatisfaction with this.

4.18 The organisation faced a substantial task in absorbing staff from more than 100 other organisations. Recognising this, soon after its inception it carried out a strategic review of its structure to establish how the organisation can remain fit for purpose in future. The review concluded that PHE's current set-up requires some change. In response, PHE is planning a change programme. This will include commissioning more expertise, embedding its role as subject experts and improving its local footprint to allow best support to local authorities and the NHS. It will also address issues about clarity of vision, purpose, roles and governance and will seek to improve communication and to simplify internal processes.

Structure and capacity of public health functions within local authorities

4.19 PHE's remit includes developing and supporting a skilled public health workforce. Generally, public health is seen as being well-placed within local authorities. In our survey, directors of public health told us that for 99% of the local authorities they covered, they thought public health had a prominent voice on their health and wellbeing board. Only 16% felt public health was not suitably positioned within the council structure. Local authorities that we visited reported some success at embedding public health within the wider local authority. However, they also highlighted a lack of understanding among colleagues of the potential that public health has to achieve beneficial change.

4.20 The director of public health's position within the local authority's senior management structure may influence his/her impact. Department of Health guidance states that within local authorities there should be direct accountability between the director of public health and the chief executive for public health responsibilities. In our survey, directors of public health said they report directly to the chief executive for 52% of local authorities. Those that do so feel better positioned within the council and report better access to cabinet members and senior officers. Directors of public health and other public health specialists have needed to develop a better understanding of local government, and new skills in political awareness and leadership.

4.21 Vacancies within local authority public health teams can limit their capacity. The director of public health leads on public health, but as at 1 November 2014 there remained 21 positions across 132 posts (16% of posts) filled by interim appointments. Prior to transition, the number of permanently filled positions within primary care trusts accounted for a similar percentage. Of those local authorities that reported figures as part of our survey, there was a 13% vacancy rate in public health teams at the end of March 2014, although 23 local authorities reported vacancy rates of 20% or more. One problem with recruitment is unfavourable pay and conditions compared with previous NHS terms. For instance, NHS basic annual leave is generally 4 days more than in local authorities. A survey of public health consultants and specialist staff in November 2013 found more than 50% of those working in local authorities expressed an interest in working elsewhere, and 83% of these were keen to work for PHE.[22] In August 2014 PHE published guidance on how the sector may tackle this issue, though the guidance is not mandatory.

22 Based on 304 respondents from local authorities (out of a total of 574 survey respondents). Centre for Workforce Intelligence, *Public health consultant and specialist survey 2013*, May 2014.

Appendix One

Our audit approach

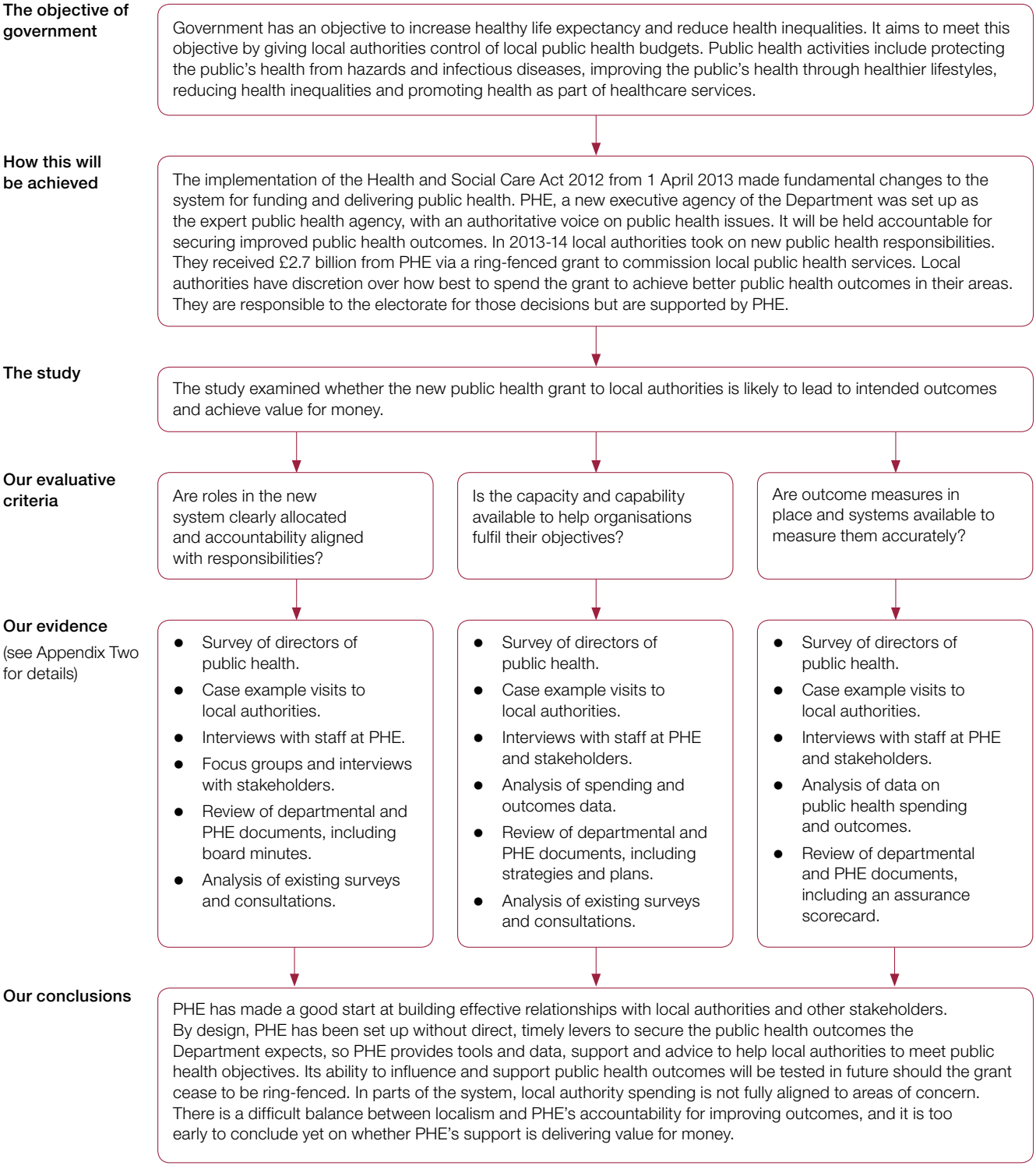
1 This report examines spending and accountability within the new public health system. It focuses particularly on the ring-fenced grant to local authorities for their public health spending. We reviewed:

- the clarity of roles and accountability within the system between the Department of Health (the Department), Public Health England (PHE) and local authorities;
- the capacity and capability of different players within the system to achieve the necessary outcomes in public health; and
- the availability and quality of the information and evidence needed both to secure public health outcomes and give assurance of necessary progress.

2 In reviewing these issues, we applied an analytical approach with evaluative criteria that consider what arrangements would be optimal for improving public health outcomes. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied restrictions or constraints. A constraint in this context is the funding settlement to PHE.

3 Our audit approach is summarised in **Figure 14**. Our evidence base is described in Appendix Two.

Figure 14
Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on whether the new public health grant to local authorities is likely to lead to intended outcomes and achieve value for money after analysing evidence that we collected between March and September 2014. Our audit approach is outlined in Appendix One.

2 We conducted a web-based survey of all local authority directors of public health. The survey was designed to fill key gaps in available information, including local use of data and evidence and local experiences of support from Public Health England (PHE). We received a response from 101 of the 131 directors of public health that we surveyed: a response rate of 77%. Some directors are shared across two or more local authorities. The directors that responded to our survey covered 112 (74%) of the 152 local authorities in England. We developed the questionnaire following discussion with the Association of Directors of Public Health, the Faculty of Public Health and the Local Government Association.

3 We conducted 4 case example visits to local authorities:

- We selected our case example locations to reflect key factors including local authority type and geographic location.
- The case example visits consisted of interviews with a range of staff from the local authority and partner clinical commissioning group, as well as local councillors. We also spoke to the PHE centre director that covered each local authority area.
- The case example visits supplemented the survey and document review we had undertaken and were designed to explore the challenges local authorities face in improving public health, as well as the quality of the support provided by PHE.

4 We spoke to a range of staff across PHE. This was to understand progress PHE had made in achieving its objectives, how the organisation was working internally, and how it felt it was working with partners. We spoke to many of its senior managers, as well as representatives covering topics including workforce management, finance, the public health outcomes framework, and its obesity and NHS Health Check programmes.

5 We consulted with NHS commissioners and providers. With support from the Healthcare Financial Management Association, we ran a focus group of clinical commissioning groups and carried out telephone interviews with a sample of NHS hospital trusts. We used these consultations to understand the pressures the changes to the system have had on the commissioners and providers of health services.

6 **We analysed existing data on local authority spending and outcomes.** We looked at 2013-14 and 2014-15 local authority budgets for public health, as well as 2013-14 provisional and final data on spending. We used these data to assess the variability of spending across the country, particularly on the prescribed categories, and trends in spending by category. We also looked at data from the public health outcomes framework.

7 **We examined key internal and external documents produced by PHE.** This allowed us to assess the quality of PHE's planning, strategy, oversight and accountability arrangements. The documentation we examined included:

- PHE's annual report and accounts, business plan and corporate delivery plan;
- a strategic document setting out PHE's priorities for the next 5 years;
- terms of reference and minutes of meetings for PHE's board as well as its key accountability, oversight and reference groups;
- PHE's assurance scorecard and supporting documentation;
- various strategies and plans, including stakeholder engagement and workforce development;
- guidance and frameworks for PHE centres and knowledge and intelligence teams, as well as prospectuses published by the centres; and
- documents on PHE's obesity and NHS Health Check programmes.

8 **We examined Department of Health (the Department) documents relating to PHE and the new public health system.** These included the framework agreement between the Department and PHE and the remit letter from the Department to PHE. This helped us assess how roles and responsibilities are divided across the system. We also spoke to relevant senior staff in the Department.

9 **We interviewed and/or consulted a range of stakeholders.** This work was designed to obtain views on: the clarity of PHE's role; its capacity and capability to carry out its work; and the main concerns within the system looking ahead. We spoke to NHS England, the Local Government Association, the Department for Communities and Local Government, the National Institute for Health and Care Excellence, Health Education England, the Centre for Workforce Intelligence, Healthwatch England, the Healthcare Financial Management Association, the Association of Directors of Public Health, the Faculty of Public Health, the Royal Society for Public Health, and the Kings Fund.

10 **We considered existing surveys and consultations from a range of stakeholders.** These included surveys of local authority staff and directors of public health, PHE staff and stakeholders, and the general public. These surveys were carried out by the Association of Directors of Public Health, the Centre for Workforce Intelligence, Ipsos MORI, the New Local Government Network, the British Medical Association and the Royal Society for Public Health.

This report has been printed on Evolution Digital Satin and contains material sourced from responsibly managed and sustainable forests certified in accordance with the FSC (Forest Stewardship Council).

The wood pulp is totally recyclable and acid-free. Our printers also have full ISO 14001 environmental accreditation, which ensures that they have effective procedures in place to manage waste and practices that may affect the environment.

National Audit Office

£10.00

ISBN 978-1-904219-58-3

Design and Production by NAO Communications
DP Ref: 10589-001