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

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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.