Communities and Local Government Committee inquiry:
The role of local authorities in health issues

Submission from The King's Fund

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Introduction

1. The Health and Social Care Act (2012) fundamentally alters the relationship between local government and the NHS. Responsibility for many public health and health improvement functions will be transferred from the NHS to local government, giving local authorities new responsibilities. Local authorities will be required to appoint Directors of Public Health, in partnership with the Secretary of State. Health and wellbeing boards have been created in upper tier and unitary authorities to improve integrated working across local health, social and wellbeing services, using tools such as joint strategic needs assessment, pooled budgets and joint commissioning to improve co-ordination of service planning and delivery. The health and wellbeing boards will also have new responsibilities to develop a local health and wellbeing strategy.

2. We are fundamentally optimistic about these changes, and have followed the development of health and wellbeing boards and the transfer of public health functions with interest. The research we have completed in these areas provides the basis for this evidence submission.

Health and wellbeing boards

The intended role of health and wellbeing boards in co-ordinating the NHS, social care and public health at the local level

3. Our report into the development of health and wellbeing boards (Humphries *et al* 2012) highlighted the following.
   a) The creation of health and wellbeing boards is one aspect of the NHS reforms that enjoys overwhelming support. The boards offer new and exciting opportunities to join up local services, create new partnerships with GPs, and deliver greater democratic accountability.
   b) Boards need to be clear about what they want to achieve. We found potential tensions between their role in overseeing commissioning and in promoting integration across public health, local government, the local NHS and the third sector.
   c) Despite the rhetoric of localism, many shadow boards are concerned that national policy imperatives will over-ride locally agreed priorities and are uncertain about the extent to which they can influence decisions of the NHS Commissioning Board. Roles and responsibilities of all new bodies need to be defined much more clearly.
   d) Although some shadow boards are taking an imaginative approach to engaging with stakeholders, the exclusion of providers could undermine integrated working. Local authorities should look afresh at ways of working with local partners rather than re-badging previous partnership arrangements.

e) Our view is that the creation of health and wellbeing boards will not automatically remove many of the barriers to effective joined-up care. For boards to succeed, a stronger national framework for integrated care is needed with a single outcomes framework to promote joint accountability.
f) The discretion given to local authorities in setting up boards means that different approaches will emerge, and some will be more effective than others. Capturing and sharing lessons learned from shadow boards will be vital to avoid simply adding a further layer of unacceptable variation to the system.
g) Our findings suggest that the biggest challenge facing the new boards is whether they can deliver strong, credible and shared leadership across local organisational boundaries. Unprecedented financial pressures, rising demand, and complex organisational change will severely test their political leadership. Board members need time and resources to develop their skills and relationships with other stakeholders.

4. ***Health and wellbeing boards have great potential to bring together local agencies to work in integrated ways. However, it is important to remember that these partnerships are new, and they will need time to develop into successful strategic bodies. An assessment will also be needed on whether boards have the levers they need to fulfil their principal roles effectively.***

Barriers to integration, including issues in multi-tier areas

5. Legal powers for joint commissioning and pooled budgets have existed for some time but few local authorities have used them. There are many examples of poorly executed commissioning in health and social care, and the current skills gap in commissioning remains a challenge for many local areas as the reforms begin to be implemented (The King's Fund 2011a). Different commissioning cycles also exist for local authorities and the NHS – they will need to be reconciled where possible, to enable health and wellbeing boards to drive joint commissioning forward.

6. The use of pooled budgets is another means of aligning resources, but currently these represent less than 5 per cent of total NHS and social care expenditure (Audit Commission 2009a). However, adult social care commissioning actually contributes around 25 per cent of its budget towards these joint arrangements, whereas the NHS invests a lot less. The imbalance in investment between social care and health in joint commissioning presents a bigger challenge than the overall total investment is small.

7. There are lessons for health and wellbeing boards from the history of local partnership arrangements. Joint consultative committees and joint care planning teams, and, more recently, local strategic partnerships have achieved mixed results in delivering jointly planned services. A recent review of the experience of local strategic partnerships also offers some relevant insights for health and wellbeing boards, namely that:
   a) important lessons can be learned from other local strategic partnerships despite their unique features
   b) they must seek to influence partners' mainstream spending and activity despite not having control of the resources
   c) there is a need to develop strong cultures to achieve shared goals
   d) there are greater challenges for partnership arrangements in multi-tier areas than for those in single tiers; despite the fact that they are voluntary,

unincorporated associations, they must recognise their strategic, executive and operational roles (Audit Commission 2009b).

8. Scotland's community health partnerships, which were established to integrate health and social care services and to shift provision from acute care into the community, have also recently been hindered by persistent siloed management of resources, staff and information (Audit Scotland 2011).

9. More broadly, our joint report with the Nuffield Trust published in January this year outlined a number of priorities for action and barriers to developing integrated care at a national level (Goodwin *et al* 2012). Little progress has been made in addressing these; there is a risk that momentum is lost during the transition as the government's reforms are implemented and that integrated care is not given sufficient priority. The social care White Paper outlined a number of proposals that will form the basis of an integrated care delivery plan due to be published by the Department in the coming months. This provides an opportunity to generate momentum – it should be the catalyst in moving integrated care from a subject for policy debate to making it happen at scale and pace across the country.

10. ***Health and wellbeing boards will need to explore a range of ways to develop a more integrated approach to commissioning and the use of resources across organisational boundaries. The Committee should consider whether boards will have all of the levers and support they need to pursue integration effectively, in light of the evidence from previous arrangements about challenges in integrating resources across organisations.***

Public health

The introduction of a public health role for councils

11. The transfer of greater responsibility for public health to local authorities provides an opportunity to improve the co-ordination of public health with other local services. The closer proximity of health improvement teams to other local authority teams and effective relationships between them will be key to delivering good public health outcomes in addressing the wider determinants of health (The King's Fund 2011b).

12. However, it is important to realise that the NHS will continue to play a huge role in public health (only around £2 billion of roughly £5 billion funding for public health will be in the hands of local authorities, the rest will lie with the NHS through the NHS Commissioning Board and Public Health England). It is of paramount importance that existing and future services that rely on collaboration between local authorities and the NHS (such as sexual health services) are not fragmented by the move to local government.

13. The move must also not isolate the skills and expertise that a large number of public health specialists have in clinical care and clinical service design. The support and intelligence that public health teams can offer to both clinical commissioning groups and local authorities will need to be carefully managed and resourced if it is to deliver the intended benefits. The right balance needs to be struck between ensuring that clinical commissioning groups don't over-rely on public health teams to deal with public health issues and health inequalities, and making sure that clinical commissioning groups don't break away from local

public health teams and duplicate their own public health functions internally, or fail to collaborate with their local authority partners.

14. ***While it is important that clinical commissioning groups benefit from the expertise of public health teams in local authorities, they should not become dependent on them. Clinical commissioning groups should be discouraged from seeing public health simply as a bought-in service, rather than as a core part of their own population responsibilities. Monitoring the development of these local relationships will be important, to ensure that those responsible for public health and the NHS collaborate and share responsibilities proportionately.***

The financial arrangements underpinning local authorities' responsibilities

15. Ring-fencing the public health budget should be a decision taken after the system has been designed, not taken beforehand as it seems to have been done. Ring-fencing is most appropriate in a system that requires specific services to be delivered; a system more focused on outcomes, strong accountability and innovation is less suited to ring-fencing. The rhetoric around public health reform, and certainly on the role of local authorities, has been focused on the latter. Over time, the ring-fencing debate will need to be revisited.

16. The Department has not to our knowledge estimated how much in total *should* be spent on public health. However, it has prescribed some mandatory functions to the sector. Arguably, there should be a bottom-up assessment of how much a specified service should cost and it should then be resourced accordingly. There is no guarantee that the existing overall pot of £2 billion is adequate to deliver the specific services required and the broader responsibilities designated to public health.

17. The Department has, however, decided to allocate funds through a 'needs formula' based on each area's standardised mortality rate in the under 75s. In the long term, such an approach is reasonable in terms of fairness based on the *national* distribution of need – although there will inevitably be lots of debate about the specific measure chosen, and about how different levels of standardised mortality rates relate to different levels of funding.

18. However, in the short term, the critical decision is how fast to move towards the new arrangements. Funds are not currently allocated according to where the formula suggests they should be, because PCTs have previously made their own decisions about resourcing public health via larger NHS budgets. Moving to the formula quickly could lead to areas that have invested in public health in the past receiving less than they have had previously, and those who have under-invested receiving windfall gains, which would clearly be unfair. On the other hand, not moving to the formula quickly is also unfair from a different perspective, ie, the distribution of needs in the overall population. Getting this balance right will not be easy, particularly as no increase is expected in overall public health budgets.

19. Finally, the evidence of securing better outcomes and value for money from the Total Place initiative was relatively underdeveloped, but did show promising improvements for local populations (Humphries and Gregory 2010). The continued focus on place-based service planning and delivery through the community budgets pilots offers a real opportunity to use money more flexibly across services to improve outcomes for patients and populations.

20. ***The government needs to be much clearer on how much funding is required for public health in total. At the moment, there is no sign it has undertaken such an assessment. Without this, even if it manages to design a perfect allocation formula for distributing that total to local authorities, there is no guarantee local authorities will be able to deliver the appropriate services to fulfil their responsibilities.***

21. ***Public health should be a central partner in driving forward place-based initiatives, as it should help to focus attention across local services on health prevention and health inequalities. However, there will be significant challenges facing areas as they develop these approaches, not least because it will require significant cultural change in ways of working to break down current organisational boundaries.***

How the impact of the new arrangements can be measured

22. We welcomed the development of the public health outcomes framework. This has bought much-needed clarity on the outcomes that the public health system is expected to deliver. However, there is much less clarity on where the accountability for meeting these public health outcomes lies in the new system. While there are plans for sector-led improvement, accountability for poor performance – for instance, on high-level outcomes such as life expectancy – remains worryingly weak, and constitutes one of the greatest risks to the success of the reforms.

23. In addition, a lot of emphasis is being placed on the power of the incentive payment for good outcomes (to be introduced in 2015/16), which will reward for progress against specific public health indicators to drive success. However, there appears to be very little consideration of what system will be in place to penalise poor performance and/or failure in the delivery of these indicators.

24. ***Public Health England will need to be transparent about the consequences of poor performance against public health indicators.***

25. The Department has also recently consulted on the arrangements for local authority scrutiny in improving the process of reconfigurations of local health services. The Department has taken on board the recommendations from our briefing on reconfiguring hospital services (Imison 2011) – to ensure local authorities take account of financial issues when considering reconfiguration plans, and for the timescales for local decision-making to be regulated.

26. The consultation also proposed that the full council of the local authority had to approve referrals to the Secretary of State. However, the use of a separate local health scrutiny function within local authorities allows for necessary impartiality in the decision-making process. Forcing collective decision-making between the full council and the scrutiny committee is unlikely to be helpful – if anything it is likely to disempower both groups.

27. Further, the proposal for the NHS Commissioning Board to act as an intermediary body for referrals about some service reconfigurations before they reach the Secretary of State poses conflicts of interest that we think should be avoided. The Board will more than likely have approved reconfiguration plans with clinical commissioning groups before these plans are escalated. It is therefore unlikely that they will be able to remain impartial in their decision to refer plans to the Secretary of State.

28. There is an alternative role that clinical senates and clinical networks, as hosted by the NHS Commissioning Board, could fulfil that could add significant value to the overview and scrutiny process. Local authorities need technical skills, support and capacity in order to perform their overview and scrutiny functions well, rather than simply as an exercise in the process (The Kings Fund 2012).

29. ***To improve on what is currently in place, a system of peer arrangements should be established and overseen by the clinical networks and senates, in which the overview and scrutiny committee of a local authority in one area dealing with a particular issue provides advice and support to another. This would mirror the arrangements for services such as cancer, where peer networks have made notable gains in improving the quality of cancer services. The proposal to refer reconfiguration plans for approval from the full council should also be dropped, to avoid disempowering both groups.***

How all local authorities can promote better public health and ensure better health prevention with the link to sport and fitness, wellbeing, social care, housing and education

30. The existence of the public health outcomes framework will help local authorities to take a strategic look across their responsibilities. However, our recent report on multiple behaviours (Buck and Frosini 2012) suggested that the government has to date primarily tackled unhealthy behaviours in silos (ie, producing separate strategies for obesity, smoking and alcohol that do not link to each other or to policies on health inequalities). We believe this is necessary but not sufficient in light of the findings in our report that unhealthy health behaviours co-occur and cluster in population groups, particularly in the most disadvantaged populations.

31. While there have been real improvements in public health in recent times, these have not been shared equally in the population, and inequalities in health behaviours have therefore widened. For example, we found that in 2003 people with the lowest levels of formal education were three times more likely to not adhere to government guidelines on all four chief unhealthy behaviours (smoking, alcohol, diet and physical activity); by 2008 they were five times more likely to not adhere to the guidelines.

32. ***Behaviour change policy and practice need to be approached in a more integrated and focused manner with a core objective on reducing inequality that is based on individuals' experience of joint unhealthy behaviours, not simply on separate campaigns on each behaviour. Local authorities, with their greater knowledge of local communities – and their greater control over some of the economic and social conditions that shape behaviours – should be in a better position to do this than the NHS. This will be a key test for them as they take on their responsibilities.***

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