Changing the local Public Health system in England: Early evidence from two qualitative studies of Clinical Commissioning Groups

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Glossary of abbreviations

CCG	Clinical Commissioning Groups
DPH	Director of Public Health
GP	General Practitioner
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
NHSCB	NHS Commissioning Board
NHSE	NHS England
PCT	Primary Care Trust
PH	Public Health
PHE	Public Health England

Introduction

In 2010, the Department of Health in England set out significant changes to the public health system as part of the NHS White Paper (Department of Health 2010a). These included the creation of a new national public health service (Public Health England, PHE), a renewed emphasis on the health improvement role of general practice (Cabinet Office 2010 p28) and the transfer of health improvement responsibilities from Primary Care Trusts (PCTs) to local authorities (LAs) by April 2013. Essentially, under the new system LAs have responsibility for taking steps to improve and protect the local population's health, and for providing the new Clinical Commissioning Groups (CCGs) with population health advice (Department of Health 2010b, Department of Health 2011a). It is argued that LAs are uniquely placed to tackle the wider determinants of health (such as employment, education, environment, housing and transport), and are therefore a natural home for a public health function focused on improving health and wellbeing across the life course (Department of Health 2011a). This takes the public health function in England back to the local government home that it left in the NHS reorganisation of 1974.

Under these changes, responsibility for commissioning and delivering public health (PH) activities will be split between a number of organisations, including: general practice; PHE; and the new NHS England (formally called the NHS Commissioning Board) , plus LAs and voluntary organisations. This creates a potentially more complex commissioning and service delivery environment for PH (Department of Health 2010a, Department of Health 2011a, Department of Health 2011b).

Whilst many commentators welcomed the move of significant PH responsibilities back to LAs (Medelin 2011) the proposals were by no means universally welcomed. Respondents to the consultation (Department of Health 2010a) expressed a number of significant concerns, which included: the role of the Director of Public Health (DPH) in the new system; the need to avoid fragmentation; ensuring independence within the public health system; and ensuring the workforce and human resource policies support the continued development of a strong specialist public health profession and the wider public health workforce. In addition, concerns have been raised that local government is receiving responsibility for PH at a challenging time, as they face a significant reduction of resources overall (28% reduction in the 2012 spending review (LGIU 2012)). This has, in turn, generated concerns for commissioners about potential tensions over health and LA budgets in areas where spend might overlap or conflict (e.g. funding of exercise schemes).

The new system was implemented in full in April 2013.The extent to which concerns turn out to be justified will to a large extent be determined by how well the elements of the new system work together (Kingsnorth 2013). In particular, the extent of collaboration and co-operation between CCGs and their local public health professionals will be significant.

The disruptions associated with wholesale organisational change are well known (Cortvriend 2004, Smith et al 2001, McKinley and Scherer 2000), as are the problems associated with health/social care

partnerships (Lewis 1999, Wistow 2012). These studies provide some up to date evidence about how these well-known issues were being perceived and tackled following the latest significant reorganisation of the NHS. In this paper we use evidence from two studies of developing CCGs and associated organisations to explore the ways in which the new system is developing on the ground. We aim to answer the following questions:

- How do CCGs perceive the issues associated with the reorganisation of PH in England?
- What approaches to tackling those issues have been adopted?
- What are the implications for future development of the new system?

The research took place at the time of maximum change, as CCGs (and other organisations) were beginning to set themselves up. The system remains in a state of significant flux, and there is therefore a danger that the issues we present here are already out of date. However, the combination of findings from two studies, one of which continued collecting data until December 2012 mitigates this danger somewhat. The studies cover a small number of CCGs, potentially limiting the generalisability of the findings, although it was striking how quickly data saturation (Murphy et al 1998) was reached for the issues discussed here.

These studies were not designed to explore the attitudes and concerns of public health employees. The focus here is upon the experiences and concerns of those outside the public health profession, who must work with public health through the transition and into the future. Concerns about the new public health system arose in the interviews and in meetings where public health personnel were present, and it is this perspective that we are presenting here. What follows is divided into three sections. A description of the methods is followed by the results, with a final section discussing the implications of these findings for those responsible for making the new system work in practice.

Methods

The first project (Study 1) (Checkland et al 2012) involved qualitative case studies in eight CCGs. A purposive sample of 'Pathfinder' CCGs in England was selected to provide a reflection of the developing complexity and incorporate a range of: geographical areas; size of developing CCGs; socio-demographic profile; numbers of associated providers and developing Health and Wellbeing Boards (HWBs); and history i.e. replication of previous commissioning administrative groupings. Data were collected between September 2011 and June 2012 and included: interviews with a wide variety of GPs and managers (96 in total) associated with the developing CCG; observation in meetings (146 meetings, 439 hours); and collection of relevant documents. Meetings observed included CCG Board meetings, CCG subgroups and where applicable localities, HWB meetings and some meetings with providers. Meeting attendees included GPs, managers and PH employees. We also carried out 2 national web surveys (December 2011 and April 2012).

The second project (Study 2) investigated how organisations in the new system were looking to tackle health inequalities. Fieldwork was conducted for 11 months between January and December 2012. Data was collected from three shadow CCGs in the North of England and similar methods were utilised including 66 meeting observations (198 hours) of CCG and wider organisational meetings e.g. HWB, Joint Strategic Needs Assessment (JSNA). Additionally, 22 interviews were carried out with CCG governing body members and people who were closely involved with CCG business, including PH staff. Associated documentation was also collected.

In both projects, comprehensive field notes were taken throughout observations and were uploaded alongside interview transcriptions into the qualitative software Atlas.ti to aid analysis. Early coding was based on literature in the area and further coding was carried out when new concepts emerged from the data and during team meetings. Results from both research projects will be presented in the remainder of this paper, illustrated by quotes from interviews and extracts from meeting observations where they demonstrate a particular issue well, represent wider views or highlight an unusual viewpoint. Care has been taken that the anonymity of research participants has also been maintained in the presentation of the data. Therefore quotations and excerpts are labelled with a study number, an ID number and a generic description of the source e.g. 'Executive meeting' or 'manager'. Further details of the methods employed in study 1 are available in the project report (Checkland et al 2012) and study 2 in a forthcoming PhD thesis (Warwick-Giles forthcoming).

Results and discussion

In this section we combine evidence from the two studies. The first sections summarise the concerns expressed by respondents about the changes to PH. This is followed by some early evidence about the approaches that CCGs (and their local PH colleagues) are taking to mitigate any concerns and to optimise their local approach.

Concerns about the new structures

CCGs were initially encouraged to set up their structures to mirror LA boundaries as far as possible (Department of Health 2011c). However, many CCGs found this to be impractical, choosing instead to set themselves up around the focus of major patient flows. Our second web survey (Study 1) demonstrated that, as at April 2012, 15 of 118 CCGs responding to the survey reported that they crossed a LA boundary, with a small number of CCGs covering patients living in three or more LA areas. Whilst all felt that this could be justified, there were some concerns about how this boundary spanning might affect their work, as local PH staff would no longer be covering the same population as their NHS colleagues. For example, this manager explained that the two local LAs with whom they would interact had different PH priorities, and this might be difficult to deal with for the CCG:

> *A: Yes, I think there's a minefield of problems there…I think it's all down to the strength*
> *of the GPs who are involved in the Health and Wellbeing Boards to make sure that the*
> *CCG health agenda is clear in that. But I think it has got, you know, potential, hasn't it, to*

get a bit tricky. Very different issues in [the two areas]. One is more rural really
'…..probably very, very different health issues, although we all share the aging issues,
and dementia, and things.
Q: But will you be producing one health and wellbeing strategy, or two?
A: Two. There's two Health and Wellbeing Boards. But we will have one health strategy
for the CCG which is… which again needs to take account of both of the Health and
Wellbeing Board priorities and strategies and things. So it's going to be a bit chaotic for
a while. [Study 1, PPI lead ID 66]

Others were concerned about the splitting of PH functions between the LA, the CCG and the NHSCB (now NHSE). It was felt that this might lead to fragmentation and loss of an overall locality-based 'intelligence':

I suppose that's my concern actually with the splitting up. If some of those functions go
to the NHSCB, ….and some stay within the CCG, at the moment we've got a really
robust sort of intelligence here within my team, have all the incidents, all the complaints,
all the safeguarding, all the causes for concern, so we have a real sort of, um, you know,
database that we can triangulate issues and that will be lost if they move to different
functions…[Study 1, CCG Manager ID 65]

Directors of Public Health (DPH) have been seen to have a key role in the transition and beyond. They need to become embedded as part of the council management team, are in many cases reporting directly to the council chief executive (as was Andrew Lansley's expectation at the outset Ford 2013, Tudor Jones 2013) and are a key member of the developing HWBs.

Finally, some respondents expressed concern that, in spite of the 'ring fencing', PH resources would be at risk in the new system:

So, in theory there will be, I don't know if I would call it accountability in the CCG to the
health and wellbeing board but local discussions should be taking place. That's our
opportunity to make sure public health doesn't have its resources taken by the city
council.[Study 2, CCG Manager M1]

The new funding arrangements were described as 'complicated', and at the time that the research was carried out it remains somewhat unclear how the proposed 'ring fencing' of PH budgets within LAs would work in practice.

Experience of disruption

As well as concerns about the shape of the new system, the associated disruption was also experienced as difficult in both studies. This PH consultant expressed concerns that important issues might be forgotten in the transition:

> *And my worry, particularly, is around some of the public health quality issues that I've picked up, are in danger of being lost in the new system, with a change of committees, losing the Clinical Standards Board, for example. So I'm just making sure that I keep those up and not forgotten, because I think that, you know, it's always an issue with transition is, you just take your finger off the pulse.*
> *[Study 2, Public Health Consultant PHC1]*

The transition has also been personally difficult for staff, with many unsure where they would eventually be employed:

> *"so the indication I've had relates to my public health remit which helpfully identified that I could end up in one of four places; so actually in terms of how informative any of those letters are… So the obvious place, the place I was anticipating would indicate, would be local authority; but obviously some aspects of public health would go to Public Health England, and ….obviously there will need to still be some availability of public health commissioning advice back to CCGs: so at the moment I've got local authority; Public Health England; CCG; and Commissioning Support Service"*
> *[Study 1, PH Manager, ID 205]*

In addition evolving policy priorities and ongoing organisational restructuring, previously been identified as detrimental to partnership working between organisations (Perkins et al 2010) and the development of relationships and trust (Miller 2003) between individuals trying to make new systems work, was recognised as potentially problematic.

Approaches to managing the transition

In both studies, respondents told us that maintaining existing good long term personal relationships was a key task. Whilst the PH *function* might be moving to the LA, individuals remained committed to working closely together. In some sites, this closeness was to be maintained by including PH staff as members of the CCG Governing Body:

> *The big risk of public health coming out and going into LA means that there is a real need for [Public Health Consultant] input. And because [PHC1] has been integral to clinical policy and all sorts of parts of the organisation it feels not right to lose her as part of the advisory position that she is in, she has been so active in that it felt right to have her as an active member of the governing body.[Study 2, GP1]*

In another site, CCG members spoke about their desire to 'embed' PH staff in their CCG at an early stage, so that the transition to the LA would be less likely to be disruptive. In one site in Study 1 they took this further, seeing the new system as an opportunity to develop even closer working with the LA, going so far as to plan co-location of LA and CCG staff. It was argued that this would enable true partnership working, and would ensure that the movement of PH did not have a negative impact. A number of sites in both studies were also keen to embed PH at the level of geographical localities as well as at the CCG Governing Body level. Some sites were also keen to maintain some PH expertise that was independent of that provided by the LA, with one site, for example, considering employing staff with PH expertise to provide commissioning support.

Where previous relationships with PH had been less effective, the changes were seen by some as an opportunity for a new start:

> *Well it's a different relationship, because it's external isn't it? It's an externally provided service, effectively, to us, from the local authority. I think if I speak in general terms, public health has got to modernise and look at how it effectively works in partnership, and how it helps in the development of local policy and strategy, but also how it provides a service to other organisations…I don't think it's as effective as it could be…reading recent history, yes. [Study 2, GP2]*

Tudor Jones (2013) found councils already exploring new creative approaches to try to overcome cultural and organisational differences to facilitate work within the new system.

Conclusions and recommendations

It is clear from our two studies that the recent large scale reorganisation brought with it many issues and concerns for those involved, both in terms of their personal job security and in terms of the service as a whole. Looked at from the point of view of senior PH officials and their Local Government colleagues, there are clearly many opportunities inherent in the new system. Tudor Jones, for example, (2013) identifies optimism within Local Government about opportunities to improve health outcomes for the local population – such as innovative uses of PH budgets and looking at wider determinants of health, and publications from Public Health England (PHE 2013a) highlight the opportunities for local priority setting within a clear framework driven and supported by the new national body. However, Tudor Jones (2013) also acknowledges a number of potential issues which resonate with our own findings, including: the time needed for the new system to bed down; the impact of local geographies and organisational boundaries which do not straightforwardly map onto one another; and local experiences of prior collaboration between local government and the NHS. A further challenge will be making the best use of resources which are now split not only across organisations but between local and national levels, for example use of social marketing (PHE 2013b).

What these studies add is some early evidence about how those issues and concerns were being perceived by CCGs and PH representatives, and about what might be done to ensure that the new system works as effectively as possible. Firstly, our studies suggest that, as the new system continues to bed down, it is important that PH staff who are making the transition to employment in their LA do not lose sight of their local CCGs, who will require practical and ongoing support for commissioning and service development. Whilst PH input to the CCG Governing Body is important, it will also be important to ensure that PH expertise is embedded throughout the workstreams and locality groups set up by the CCG as well as working effectively with HWBs and the wider LA. Secondly, the key to maintaining high quality collaborations during the transition and beyond is clearly to value and build upon personal relationships and historical experiences of working together. It is vital that these local social networks are not lost in the face of wholesale structural change. Finally, at the time of carrying out this research there remained considerable concern about the funding of the new system. LA budgets are under tremendous strain overall, and those with an NHS background expressed significant concern that resources would be 'lost' to the LA. Given these strains, it would seem more important than ever for health and local government to work more closely together, no longer seeing resources as 'mine'; or 'yours' but as 'ours', to use together to improve the health of the local population. Making this work in practice remains one of the key challenges for the new system.

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