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PHOENIX: Public Health and Obesity in England – the New Infrastructure eXamined

First interim report: the scoping review

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Executive Summary

The PHOENIX project aims to examine the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health.

The scoping review has now been completed. During this phase we analysed: Department of Health policy documents (2010-2013), as well as responses to those documents from a range of stakeholders; data from 22 semi-structured interviews with key informants; and the oral and written evidence presented at the House of Commons Communities and Local Government Committee on the role of local authorities in health issues. We also gathered data from local authority (LA) and Health and Wellbeing Board (HWB) websites and other sources to start to develop a picture of how the new structures are developing, and to collate demographic and other data on local authorities. A number of important themes were identified and explored during this phase. In summary, some key points related to three themes - governance, relationships and new ways of working - were:

- The reforms have had a profound effect on leadership within the public health system. Whilst LAs are now the local leaders for public health, in a more fragmented system, leadership for public health appears to be more dispersed amongst a range of organisations and a range of people within the LA. At national level, the leadership role is complex and not yet developed (from a local perspective).
- Accountability mechanisms have changed dramatically within public health, and many people still seem to be unclear about them. Some performance management mechanisms have disappeared, and much accountability now appears to rely on transparency and the democratic accountability that this would (theoretically) enable.
- The extent to which 'system leaders' within PHE are able to influence local decisions and performance will depend on the strength of relationships principally between the LA and the local Public Health England centre. These relationships will take time to develop.
- Many people have faced new ways of working, in new settings, and with new relationships to build. Public health teams in LAs have faced the most profound of these changes, having gone from a position of 'expert voice' to a position where they must defend their opinions and activities in the context of competing demands and severely restricted resources. Public health staff may require new skills, and may need to seek new 'allies' to thrive in the new environment.
- HWBs could be crucial in bringing together a fragmented system and dispersed leadership.

The next phase of data collection will begin in March with the initiation of case study work. National surveys will be conducted in June/July this year (2014), and at the same time the following year. In this work, we will further explore the following themes: relationships, governance, decision making, new ways of working, and opportunities and difficulties.

Overview of PHOENIX

The PHOENIX project is examining the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health. The project takes obesity as a prism through which to examine the response of public health systems to a 'wicked issue' in health improvement [1]. It will examine the approaches taken by key actors; how decisions on a wide range of activities including commissioning are made; and how the resulting spectrum of services and activities changes over time in light of the reforms to public health that have taken place since April 2013.

This project aims to identify the extent to which, how and why opportunities within the new system are being realised; challenges are being overcome; and concerns are being addressed. In the scoping review, we conducted a critical analysis of the impact of the structural reforms on the public health system and its likely ability to improve population health and tackle obesity (as an example of a complex problem). We also started to develop a clearer understanding of the relationships between different components within the system at national and local level. In order to guide the next phase of the research, we examined the extent to which the reforms present opportunities or threats to the public health system in terms of reaching health improvement goals, and we began to look for evidence of how any beneficial effects might be enhanced, and how any problems might be addressed.

A great deal of data was gathered and analysed, and will inform the next stage of the research. This interim report does not summarise all the data. Rather, it outlines three important themes that have emerged during the scoping study phase: governance of the public health system; relationships within the new public health system; and new ways of approaching or 'doing' public health subsequent to the reforms.

Methods

A number of activities have been carried out during this phase:

1. We gathered and analysed the main policy documents related to the health and social care reforms, as well as responses to those documents (and to the Health and Social Care Bill) from 12 organisations/groups representing a range of stakeholders. We identified important opportunities and key concerns at various levels, and for various elements within the system – in particular, related to leadership and governance, structural capacity, and public health practice.
2. We conducted 22 semi-structured interviews with 23 individuals (one was a joint interview) at national (n=10), regional (n=5) and local (n=8) level. Interviewees included individuals working in or with Department of Health, Public Health England, NHS England, Local Government Association, Local Authorities (both officers and elected members), and Health and Wellbeing Boards, as well as 3 individuals with other stakeholder organisations.
3. We have carried out a detailed analysis of the oral and written evidence presented at the House of Commons Communities and Local Government Committee on the role of local authorities in health issues (Eighth report of session 2012-13, volumes I and II, printed 20 March 2013). This further enriched our data and analyses.
4. We have gathered data from Local Authority and Health and Wellbeing Board websites and other sources to start to develop a picture of how the new structures are developing, and to collate

demographic and other data on local authorities. This has been used to purposively select our case study sites and to inform the next stage of the research.

In this project, we draw on a wide range of relevant and useful aspects of systems thinking to enable us to develop an emerging understanding of the complexities of what we refer to as a 'public health system'.   Our analysis of the health sector reforms used a dynamic public health system framework[2,3] to guide a critical examination of the theoretical impact of the reforms on different elements within the public health system. We also analysed stakeholders' thoughts concerning the opportunities and potential areas of concern associated with the reforms. Finally, we analysed our interviews with key informants (N=22) across the system to assess, at this very early stage, the progress being made towards policy objectives contained within the reform programme. In this brief, we do not present the entire analysis, but we draw on it to discuss three broad themes that emerged: governance; relationships; and new ways of working.

Findings

Governance

The policy documents relating to the introduction and implementation of the reform programme show that the concept of localism dominates within the theme of governance. Many of the relevant policy documents stress the importance of developing strong local leadership and ensuring accountability to the local populations. The new system is supposed to "be built on confident local leadership within a clear national framework".[4] Accountability frameworks are being driven by the push for increased autonomy for providers and professionals (i.e. freedom from centrally-driven diktat), and by an emphasis on greater democratic legitimacy.   The aim is to introduce a system that is locally-led, but with "central strategic leadership providing the context for that local action".[4] The Public Health Outcomes Framework (PHOF) is intended to be the foundation of accountability arrangements. However, councils are primarily accountable to their electorates. Additional accountability arrangements for the money that the Department of Health (DH) allocates to local authorities for public health rely on [5]:

- transparency. Public Health England (PHE) will publish data on national and local performance against the PHOF. This will enable democratic accountability for performance against those outcomes; make it easy for local areas to compare themselves with others across the country; allow local people to assess the performance of their local authority; and increase the incentives for local authorities to improve their performance;
- requirements relating to the proper use of the ring-fenced grant. Each receiving local authority will have to set out how the authority has spent its grant, and councils will be clearly accountable for ensuring that grant conditions have been adhered to;
- delegated functions. The Secretary of State has the power to delegate particular functions to local authorities, and councils will be accountable to the Department for exercising them; and
- health premium incentives. The DH will incentivise progress against health improvement indicators through the use of a 'health premium' in grant allocations.

Alongside the DH's role as national strategic leaders, PHE is intended to "provide a focus for the whole public health profession, through leadership, a powerful and authoritative national voice for public health in England".[4]

During the passage of the Health and Social Care Bill, stakeholders expressed a number of concerns relating to governance within the new public health system. Some expressed the view that with public health moving away from the NHS, their advice and influence might wane, and that the public health workforce might lose their independence and ability to challenge powerful interests. Further, with all the flux in the system created by the reform process, many important posts (particularly Director of Public Health (DPH) posts) might remain unfilled or filled with temporary appointments, which could affect both continuity and strategic influence. Some noted the confused and complex lines of accountability and responsibility between the various bodies involved in commissioning public health services. A further concern was that some Local Authorities might be slow to realize the full extent of their public health responsibilities across all three domains of public health (health improvement, health protection and health services).[6,7]

Our interviews indicate that the reforms have succeeded in progressing the localism agenda. Local authorities tend to focus their gaze on their local populations, and are resistant to the idea that they might be 'told what to do' by national guidance. This might affect their relationship with PHE as a national 'leader' for public health:

> "Because of the nervousness in local authorities about being performance managed, there is still an issue to be resolved about what exactly PHE does, versus local public health teams" (LA informant).

Public health teams which have moved into Local Authorities from the NHS could also find this public accountability difficult to get used to – rather than being accountable to a rather remote regionally or nationally situated civil servant, they are now first and foremost accountable to the Leader of the council, working in the same building as them.

It seems clear that not only has leadership for public health been devolved, to an extent, but also that leadership has been 'distributed' across multiple local organisations. This is partly due to the fragmentation of responsibilities around public health issues, but also due to the creation of Health and Wellbeing Boards (HWBs). Fragmentation means that it is "vitally important to have a shared vision and real leadership" (national level informant). However, the 'leadership challenge' is more complex now because the partnerships are more diverse (PHE regional informant). It seems clear that public health leadership is no longer focused on public health professionals. Other actors – in particular the other senior executives (Directors of adult social services and children's services), and elected members – are also key to public health leadership at a local level. One informant felt that LAs will provide stronger public health leadership than Primary Care Trusts (PCTs) ever did, because "Councillors are incredibly committed to improving the lives of their local residents and public health sites very squarely with that" (LA elected member). A regional level informant in NHSE commented that there is an advantage in the fragmentation of public health in that public health can be more "embedded in everything we do" – "we all own a piece of this and it's my responsibility to do it".

Two governance-related issues came to the fore in our analysis: one, that localism will inherently mean greater variability. Local areas will go about addressing their public health concerns in different ways, which may or may not be to the satisfaction of the national system leaders. It is not yet clear whether or how national system leaders will respond to this. In particular, the role of PHE in relation to this appears problematic. It is clear that PHE will at best only be able to 'influence' local level public health action. And that influence will only be possible if they have strong and positive relationships with key actors in the local

authorities. There are early indications that these relationships will take considerable time to be built, and may rely on greater numbers of staff being available at the PHE Centre level than are currently there. In the mean time, there may be some frustration from various parts of the system that positive change or influence is not seen early enough. In our interviews, an NHSE informant felt that public health needed much stronger national leadership, and felt frustrated that PHE were not doing more "to really drive local authorities to working up the strategies around their key health requirement areas". A LA informant noted that "There is definite tension between the different accountability frameworks that operate for local government as compared to the other players in the system".

The second issue is that the influence of public health *professionals* in the leadership of the local public health 'system' will depend on many factors, including structural arrangements, the size, strength and experience of the team, their 'power' relative to others in the system, their control over the public health budget, and their role and position on the HWB. However, the most fundamental factor, it appears, may be the type and strength of relationships they are able to develop with colleagues across the council. All these factors, of course, are intricately interrelated. Again, it will take time for these relationships to develop, and public health teams will, in many cases, need to work out where it sits in the dynamics of local government, and where its voice can be most effective (national informant). Several informants (at national and local level) suggested that some public health teams (and DsPH in particular) are currently struggling with this.

Data from informants suggests that public health professionals have, on the one hand, been given new opportunities to influence the approach taken to public health across the whole council. However, on the other hand, "public health leadership will take time to be rebuilt" (DPH informant A). This is partly because of the upheaval and continued flux within the profession, but also because those public health staff working within local authorities must now operate within a broader 'corporate model'. Directors of Public Health, it was suggested, might now have less power to do things that aren't seen as "delivering the corporate responsibilities of the council" (DPH informant B).

According to the interviews, accountability in the new system will rely most heavily on transparency, and the democratic accountability that this transparency will enable. The DH are in a new position where they can no longer tell the key actors what to do, yet as 'system stewards', they need to "make sure everyone's doing what they're supposed to be doing and dealing with that if they're not" (national DH informant). How this will be handled appears to have been left as something of an afterthought. One central level informant suggested that in the absence of performance management, there ought to be new mechanisms that help to ensure that a range of services (like smoking cessation) are not simply dropped (e.g. through lack of funds) by the new commissioners (local authorities). However, others suggested that HWBs will be able to hold the local system to account "in ways that no other part or agency within the system can do" (national PHE informant). In particular, public health spend will (potentially) be scrutinized much more carefully by elected members, by opposition party members, and by the local population (particularly through the local media). A national level informant noted that now, more than ever, organisations have to learn how to exert authority in a world where they don't have direct levers. It was suggested that this requires 'transformational leadership'.

It has been suggested that LAs, with their history of 'sector led improvement', are good at sharing good practice and learning from each other. This may well enable innovation to flourish. Where data shows a council is not performing well against the PHOF, it is expected that pressure to improve will come from

within the council, from the local population, and from PHE (through 'influence'). None of these pressures, though, may be particularly strong. One local level informant felt that it was 'nonsense' to think that local residents will exert pressure over the way LAs carry out their functions that are about addressing inequality through the wider determinants of health: "you can't argue with the principle of local accountability and the democratic imperative but don't overplay the way it's going to handle performance management".

Relationships

The drive for localism affects relationships as well as governance. The reforms aimed to shift local practitioners and professionals' relationships towards local people and patients, as opposed to with government. There is also a strong emphasis on integration within the policy documents, with new HWBs given the task to bring the whole system together at the local level: "They [HWBs]will maximise opportunities for integration between the NHS, public health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population."[4] The ability of local authorities and public health professionals "to plan and build the local relationships and partnerships … will be key to implementing the new public health system".[4] As stated above, LAs are seen to be the leaders in this endeavour, and have been given new functions to support integration and partnership working. In taking forward their commissioning responsibilities, LAs are expected to develop new relationships and approaches to improving health and wellbeing.

In response to the proposed reforms, stakeholders expressed their hope that the moving of public health teams into local government might provide new opportunities for collaboration, including shared services, intelligence and analysis, and cross-authority public health commissioning. On the other hand, though, it was noted that LAs provide a very different 'culture' from PCTs, and that both councils and public health professionals will need to adapt to each other. Individuals moving from the NHS to local government will see very different organisational contexts, histories, structures, ways of working, and possibly different boundaries too. Different areas have different starting points in terms of the extent of joint work between public health and LAs, and this will influence how far and fast changes are made. In response to the reforms, other concerns were raised about the loss of regional structures (SHAs), and there were questions about how PHE will cope, incorporating the functions of about 70 former bodies, and being quite 'thin' on the ground at regional level. Some commentators also wondered whether the reforms (particularly in the context of extreme budget pressure) would encourage the right behaviours between the NHS and local government. It was suggested that some services and functions may slip between the cracks.

The reforms created an unprecedented number of new organisations, as well as changing the roles and responsibilities of existing organisations. Inter-personal and inter-departmental relationships within organisations, and between organisations locally, regionally and at national level, have all seen fundamental change. Yet the upheaval to the system, the fragmentation of responsibilities, the confusion over roles during the transition, and the integration agenda all make the building of strong relationships more important than ever. In addition, given the removal of many of the mechanisms for and emphasis on performance management, the new system relies heavily on 'leveraging' – exerting influence without direct levers. It was clear to several informants that the only way to "leverage the system to implement and drive impact" (national PHE informant) is to build strong and effective relationships and networks.

Our interviews highlighted that organisations and public health teams have prioritised 'relationship building', and that this has consumed a lot of time and energy. PHE, like others, are still finding their feet as new

organisations, and at national level, one informant commented that they are being largely reactive at the moment – reacting to lobbyists and advocates with agendas to address. The task has been greater because individual agencies are having to "get their own house in order" at the same time as creating the partnerships needed for the system to work (PHE national informant). The scale of the reforms mean that it's all taking time to 'bed down' before relationships can start to be rebuilt. One DPH mentioned that he and his team had spent so much time and effort building relationships internally with the council that they hadn't achieved what they had wanted to achieve in terms of developing relationships externally with the voluntary sector, schools and GPs.

A number of DsPH and their teams were previously joint appointments with the LA, so many relationships are not new. Several informants noted that a record of working together has helped, because relationships already existed. However, given the 'newness' of the system, there is merit in making an effort to 'start again' – one DPH informant already had good relationships in the Council, having worked there for over a decade, but during transition, he found it very useful to have a personal induction with all cabinet members and all new director colleagues. Several informants also noted that former work 'relations' may now be working in quite different organisations with different roles, so some effort needed to be put into understanding this difference: "I'm having to re-establish the relationships in the NHS … the CCG is a very different beast to the two PCTs it replaced" (DPH informant).

There is a big shift to be made in the relationships between regional PHE staff (many of whom used to work within SHAs as performance managers) and local public health professionals (many of whom used to be in PCTs). This relationship is crucial to the ability of PHE as a whole to influence the system. One regional PHE informant noted the awkward position that they are in – they don't want to look like they're opponents of LAs, but, if they are concerned about, for instance, services being cut back, it is not clear how they should progress. From a DPH perspective, one informant said that a lot of their engagement with PHE has felt top down so far, with them providing resources, campaigns, information, etc. From a PHE perspective, a regional level informant suggested that work so far with LAs has been unmanaged and driven by opportunistic conversations. However, this relationship will likely be varied across the country, and change substantially over time. PHE are ostensibly in a position of 'selling a service' to LAs, and they will have to prove their worth and add value at this local level. This challenge will be greater given that PHE centres (and NHSE Local Area Teams) are relatively very 'thin' (in resources). Some regional level teams (in both PHE and NHSE) may be too under resourced or too thinly spread, with areas of responsibility that are too great, to have a meaningful relationship with local commissioners (LA elected member/chair of HWB). PHE informants at national and regional level noted the importance of networks, as a means of compensating for the lack of resources in PHE, and as a means of 'distributing' leadership. Since quite a few networks have been casualties of the reforms, some effort is now going into rebuilding some of them.

A further significant set of relationships is that between public health teams and their LAs. It was clear from interview data that in order to develop strong relationships between public health teams (and other public health professionals in PHE) and LAs, they will need to understand the world of local government. Public health staff now have to engage with and reach a different audience, and work in quite different ways. They may have to re-think the way they frame their arguments and communicate the evidence. An elected member commented: "There is some 'unlearning' to do as well as a lot of learning".

The political environment is an important contextual issue in relationship building. If a DPH develops a good relationship with their portfolio holder, they could have better access to the media, might be able to have a more influential voice, to challenge other members of the LA, get resources shifted, and so on. Some elected members can be powerful and ambitious movers, so it's important to develop that relationship with them. Also, new relationships between directors (e.g. between the DPH and the Directors of Children's or Adults Services) could be quite fruitful. Interviewees suggested that new or stronger/deeper relationships between public health teams and service areas within LAs (e.g. leisure, travel, housing, etc.) are already being seen. LA interviewees noted that there are opportunities that will come from the fact that the Council is such a big organisation, but also one that is so well linked locally. Also, an elected member commented that the council cabinet committee now debates health issues and brings a far wider range of voices to the table.

Relations between public health teams and their LAs may not be easy. One interviewee highlighted that where the public health team has come into the LA as a "new boy", they may have to go through a period of proving themselves alongside long-established directors who run very large sections of the LA and have a lot of staff working for them. Their success and degree of influence will fundamentally depend on the quality of relationships they can build. It was suggested that structural issues, such as who DsPH report into, does not matter so much as whether the DPH can function, and whether their manager and colleagues respect what they do, and will support them.

Another factor affecting the development of relationships is that people are "very worried about autonomy" (PHE national informant). This appears to be the case at national and local level. DsPH especially will have to manage their 'independent voice' very carefully in light of the need to 'tow the corporate line'. One elected member talked about members of the public health team, over time, being "dragged into the council agenda".

A further new alliance that has been highlighted by interviewees is that between GPs and elected members – some good relationships have formed between CCGs and LAs where GPs have come together with elected members and found they have much in common. This could be an important relationship that influences the work of HWBs. However, it was pointed out that relationships with CCGs could be difficult if they are not engaged positively with the HWB. An elected member remarked that relationships between public health and CCGs might also become strained as public health in local government might take some things away from general practice if they feel it's too expensive, or can be done better elsewhere. It is likely that the relationship between CCGs and LAs will be very important in realising the integration agenda.

There were suggestions in the interview data that the paucity of resources (and the wider all-pervading sense of austerity) is 'forcing' people to work together in different ways. The state of upheaval, and the lack of clarity over roles and responsibilities, has, in some cases, helped to build a sense of camaraderie – "we're all in it together" (NHSE regional informant). However, the development of strong relationships has been hindered by the fact that so many people are in new roles, and the fact that those roles have not always been terribly clear. In some areas, interviewees told us that relationships between PHE and NHSE are very underdeveloped.   The fragmentation of the system has, in some circumstances, created tension – for instance, where not all actors are perceived to be working at the same pace, or to be taking sufficient leadership over their responsibilities, or where pots of money have been wrongly allocated. A LA

interviewee said that it takes strong leadership to encourage people to look beyond that and to think instead "across the system".

New Ways of Working

The reforms aimed to encourage new ways of working for those in the public health system (and wider health and social care systems). Changes are intended to see a focus on outcomes (and specifically at local population level), brought about by "local leadership and wide responsibility across society".[7] This 'wide responsibility' is supposed to encompass a move towards a more preventative agenda, tackling the wider factors that influence health and wellbeing across the life-course. This approach reflects the government's core values of freedom, fairness and responsibility by, as it states in the public health white paper: "strengthening self-esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier".[7]

Responses from stakeholders to the reforms were largely positive regarding the shift of public health responsibilities into local government, and recognised a greater potential to address wider determinants of health through the full range of local government functions and partnerships.   The push for closer working and integration of health and social care was also widely applauded by most stakeholders, with the hope that this would lead to people's needs being recognised and responded to in a holistic way. Some stakeholders were hopeful about the government's new approach to broadening responsibility for public health though the 'responsibility deal'[8], which could encourage businesses to be more involved in tackling the health-related impacts of food, alcohol, physical activity and the workplace.

However, a number of concerns were also raised. Some stakeholders expressed a fear that with public health moving 'arms-length' to the NHS, providers may become less embedded within the local public health systems. Some wellbeing services could end up being disconnected from each other and from wider support (for example, smoking cessation services may have no clear protocol to refer clients to enablement support such as assistive technology, or to establish support for carers). It was pointed out by many responding to the reforms that the shared or split responsibilities for the commissioning of services is extremely confusing, and that some things may fall through the gaps as a result. Service fragmentation could threaten integrated care pathways, information sharing, education and training, and development of positive working relationships.

There was a concern that considerable discretion is being afforded to individual LAs to interpret the full and detailed scope of their new functions and services. In addition, with the heavy focus on localism, and the emphasis on 'freedom' from central government interference, it was suggested that the reforms may not encourage positive changes to macro-environmental factors (through, e.g. legislation at national government level). There was also a concern that the regional level of the public health system may end up focusing on health protection to the detriment of health improvement and health services public health functions. Indeed, there were particular concerns about the core public health functions related to health services planning, in the absence of explicit mechanisms for public health input and advice to the commissioning and provision of healthcare services.

The interviews gave a strong sense that people are finding new ways of working in the new system. Informants at local, regional and national level agreed that there is now greater potential for public health to become embedded into the thinking behind all kinds of decisions being made within local authorities, which

will help to "take decisions back upstream" (national PHE informant). A regional PHE informant felt "we stand a better chance of being able to think about how we're responding to people at various stages in their lives in various settings" than they could previously. They now have better access to older people's services, environment, housing, and so on, than before, and so they have the opportunity to "leverage change" there. There is greater potential for public health teams to make a difference through using mainstream budgets in local authorities to promote population health and reduce inequalities, rather than having a 'small agenda', with little bits of money being used to commission lots of small projects.

Several interviewees at local level suggested that they are now working differently. One DPH said that by embedding wellbeing and public health into all services, they are working to a different model/framework now, and they are working out how to embed the principles of public health into each service area. An elected member explained that her council have developed what they think is a good social model for public health, looking at root causes. Another elected member comments that the PH team (which is not dispersed) in his LA now have stronger connections with other council departments and have been working with them, for instance, on the obesity agenda. There has been a lot more focused thinking and debate on cycling as a result. Having debates on such issues in the cabinet committee also brings a wider range of voices to the table, which leads to innovation and new ways of doing things (elected member informant). One interviewee, who has experience of working with a number of HWBs, said that he has seen "good things happening" around issues like fuel poverty and loneliness, that he thinks wouldn't have had proper 'air time' in a PCT. He also points to a greater emphasis on the wider determinants of health, and a linking up of health and social issues: "Some of the GPs have been really relieved that … they've got a place [in the HWB] where they can take information about all the things that are not so much related to the practice" but which concern their patients – the social problems. The same interviewee also said that he has seen at least one HWB organise its high level priorities using a life-course approach, indicating that the focus on this in policy documents might have percolated to local level.

There is a strong sense that the reforms – and in particular the relocation of public health teams within local authorities - offer new opportunities to work in different ways. However, whether those opportunities are taken up will depend on the strength of relationships – particularly within and between LAs and HWBs – and on the ability of individuals to adapt to new ways of working, which will often require new/different skills. One DPH informant, who described strong working relationships with his LA, explained that he and his team were now able to capitalise on new opportunities. An elected member suggested that public health teams have a relative 'freedom' within LAs, from the "constant churning out of directives from the NHS central machine".   The image presented here is of a public health team that is emancipated and liberated to take up new opportunities. However, another DPH informant described less developed relationships and power struggles going on with other directorates. This DPH explained that he had limited opportunity to take on additional responsibilities, and his role appeared to be to protect, as far as he could, his former role/responsibilities. The image presented by this DPH is one of a rather battered and beleaguered public health team, having to defend and fight its corner.

In order to thrive in the LA setting, and build strong relationships with the rest of the council, public health professionals need to adapt in a number of ways. First, their position within the dynamics of the organisation have changed. A regional PHE informant explained that "public health within the NHS were almost like the expert voice that sat, sat on the corner here and they could give their opinion". Now, they are within the council with everybody else, and if they want to get their opinion anywhere, they have to

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submit a paper, which will go through the lawyers, an 'exec group', maybe a sub-committee, and so on, and then it might come back to them in several months' time. Other interviewees intimated that public health teams needed to shift to a more 'defensive' approach. Particularly in the context of reduced funds, it was suggested that public health people now have to put together business cases for investment, and they have to show how their initiatives will produce a return on investment and help to create a more sustainable system (national informant). They now have to face debate and opposition, and be accountable to the leader of the council (elected member informant).

There is a layer of scrutiny within LAs that perhaps wasn't there before, and a national informant suggested that LAs will look at the contracts that have been commissioned by the NHS with a fresh eye, and will have no qualms about decommissioning services that are not delivering the outcomes. It will be the responsibility of public health teams (with support from PHE) to demonstrate that interventions and activities they commission are effective. A DPH informant also felt a great pressure to reduce spend on services since moving to the LA, and felt that the scope to do anything innovative and new is being drowned within this pressure. This pressure to save money has also meant that some public health teams have re-tendered a number of services, with a focus on improving cost-efficiency.

It was suggested by several informants that public health professionals have got to learn how to take on the managing of politics. In order to do this, they will have to portray the evidence in a way that engages a broader audience that is very much 'place-based'. They need to take stock of who are their main proponents and where opposition is going to come from; who are the people that are most influential, and how do they get amongst all that to influence the decisions in the council chamber. One national informant said this is "a set of public health skills that perhaps we haven't had to use them [sic], they have atrophied in the NHS, but in local authority you're going to have to fight for your action". He continues: "I've seen people slaughtered in council chambers because they just haven't had good enough oratory and persuasive skills and they don't prepare well enough".

In influencing and persuading their colleagues, it was suggested that public health professionals need to think about how they frame their argument in different ways. There were suggestions that the 'language' and means of communication need to change. For instance, in order to resonate with elected members and other key local authority personnel, it was suggested that public health staff would do well to come at issues like obesity through different lenses: green spaces, hot food takeaways, cycling/walking, sustainability, carbon reduction and so on (regional PHE informant). They should also try to 'situate' issues with local stories, in order to 'push the buttons' of elected members. A national level informant suggested that democratic accountability is a new dynamic that will also influence the way public health teams need to work. He suggested that they need to have a "serious dialogue" with the public about what's important now and in the future. They will need to convince the politicians and the public to invest now for change that will take a long time. The way in which the arguments are framed, and how the media choose to portray it, will be important.

Several informants suggested that HWBs are allowing a new way of working to develop between the council and the NHS. An informant who is a HWB chair with experience of a range of HWBs, said that in some cases the HWB "has cleared away some of the historic antagonisms". There is often a high sense of informality, people working together to learn about an issue from different viewpoints – "they've found a way of being themselves". A LA informant suggested that HWBs could be an effective vehicle to getting alignment

between political leadership, professional expertise and managerial effectiveness. However, two informants explained that in the transfer of public health, and with the increased fragmentation of the system, there are various duties that fell through the gaps, and ended up with the HWB ("for want of a better place"). This means that some HWBs have to do a lot of "signing off on stuff" which limits their ability and time to be creative and to change the way the system works (elected member informant).

Several informants pointed out that PHE needs to play an important role in helping to 'sell' the public health arguments to a wider audience. However, informant interviews highlighted that there is some confusion amongst various actors as to PHE's role. A national informant in NHSE was frustrated that PHE was appearing too weak. He felt it's no good PHE just producing guidance, they have to "strongly influence" and take "strong leadership on what LAs will do". An LA informant said he is "still unclear about what PHE does" – particularly with regards to local public health teams. An elected member said, in relation to PHE's role regionally, outside of health protection, "I don't think anyone really understands what it's for".

Discussion

In progressing the reforms, the government's aims, with respect to our three identified themes – governance, relationships and new ways of working – were to develop a system that, in the spirit of localism, enhances local leadership, builds and prioritises relationships between professionals/practitioners and local people/patients, and replaces performance management with democratic accountability. The reforms aimed to develop new ways of working within the health, social care and public health systems that are focused on outcomes (rather than processes), the preventative agenda (and addressing the wider determinants of health), and a more holistic 'life-course' approach. This would be achieved through better integration of health, social care and public health.

The reforms have had a profound effect on leadership within the public health system. It is not yet clear that the DH, along with PHE, are realised as "a powerful and authoritative national voice for public health in England".[4] It is apparent that LAs are seeing themselves and are seen as the local leaders for public health, given their new roles and responsibilities. At local level, though, the position of DsPH as 'the leader' for public health is no longer a 'given'. In a more fragmented system, leadership for public health appears to be more dispersed or distributed – amongst a range of organisations (e.g. sitting on the HWB), and amongst a range of people within the local authority (e.g. portfolio holder for health, Director of Adult Social Services, Director of Children's Services, leader of the council). The influence of the DPH amongst these will depend on the strength of relationships and his/her ability to adapt to new ways of working and to thrive in a new and different environment. Key amongst those who (potentially) have more influence in the new system are LA elected members and GPs – both of whom tend to have a very local focus, with a 'fingertip' knowledge of a lot of local people and the stories they tell.

In terms of accountability, it is clear that a great deal of performance management mechanisms have disappeared. People still seem to be unclear as to the new accountability mechanisms, and what would happen if the 'system leaders' (DH and PHE) were not happy with what LAs were doing in terms of public health (health improvement) activity. Much accountability appears to rely on transparency, and the democratic accountability that this would (theoretically) enable. Where a LA is not performing well against the PHOF, pressure to improve is also expected to come from within the council, and from PHE. Leaders are expected to be able to 'influence' local decisions and performance, predominantly through the relationship between the LA and the local PHE centre. These relationships are in an embryonic stage, and will take time

to develop. The strength and quality of these relationships may also be limited by the small size and large scope of the team at PHE centre level.

Many people have faced new ways of working, in new settings, and with new relationships to build. Public health teams in local authorities have faced perhaps the most profound of these changes. It appears that public health professionals have gone from a position of 'expert voice' to a position where they must defend their opinions and activities in the context of competing demands, and severely restricted resources. This will require skills that may be out of practice or undeveloped. In this new political environment, they must engage a range of new actors – particularly elected members, and officers in other service areas, in order to develop trust and influence across the whole council. They will need to use language and arguments that resonate with these people. In re-framing their arguments, they also need to think about engaging with the public, for instance through the media, to convince them of the need to invest in broader, long term public health approaches, and to bring them in as responsible partners.

Given the fragmentation of the system, and the 'distributed' nature of local leadership, HWBs are important vehicles for bringing the elements of the system together and for developing shared agendas between health, social care and public health. It seems clear that the potential for HWBs (within the wider PH system) to drive new ways of working and improve integration is there in theory. However, whether that potential can be realised remains to be seen.

Next Steps

The next phase of this project will involve a national survey of all 152 upper tier/unitary LAs to be conducted in June/July 2014, to gather information on structures, processes, relationships and resources at local authority level. This survey will be followed up in June/July 2015.

We will take obesity as a 'tracer' condition to explore issues in depth, and in particular to investigate the extent to which there are 'new ways of working'. We will examine 3 broad 'activity areas' that are spread across a spectrum of activities and which require a multiplicity of relationships. These areas are: the development of obesity pathways, working with schools, and engagement with LA planning.

We will begin case study work in March. We are currently recruiting 8 purposively selected upper-tier or unitary LAs, and will conduct initial face-to-face interviews with the DPH (or their nominated representative) at each site. Following initial interviews and the collation of site-specific documentary data, we will identify which 4 case study sites to study in-depth, and which to include as 'lighter-touch' sites. In the in-depth sites, we will gather deep and detailed knowledge of those issues raised in the scoping review. Taking a narrative approach, we will explore, in relation to our three obesity activity areas, the act (what is done), the scene (the context in which it is done), the agent or actor (who does it), the agency (how it is done), and the purpose (why it is done).[9] We will conduct face-to-face interviews (approximately 20 per site), and observations of meetings (at least 4 per site), and will examine local planning, commissioning, and implementation documentation and reports. In the four 'lighter-touch' sites, we will gather further data on the local systems (structures, mechanisms and organisational issues) to broaden the context for our in-depth analysis. This data will be gathered through interviews (either face-to-face or by telephone; up to 3 in each site) and documentary analysis.

Data collection and analysis will run concurrently, and this phase is expected to last until September 2015. A second interim report will be produced in Jan/Feb 2015 to report on early findings.

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