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

**Final report
April 2016**

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List of Abbreviations

CCG	Clinical Commissioning Group
CSU	Commissioning Support Unit
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
HWB	Health and Wellbeing Board
HSCA12	Health and Social Care Act 2012
JHWS	Joint Health and Wellbeing Strategy
LA	Local Authority
NCD	Non-communicable disease
NCMP	National Child Measurement Programme
NHS	National Health Service
NHSE	National Health Service England
PCT	Primary Care Trust
PHE	Public Health England
SPD	Supplementary Planning Document

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Executive Summary

The PHOENIX project examined 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. This report is the fifth and final report for the project. It should be considered alongside a first interim report (Gadsby et al 2014), focusing on our scoping study phase; a second interim report (Peckham et al 2015) focusing on our phase one case study research and first national survey; a first survey report (Jenkins et al 2015) and a report of the second survey (Jenkins et al 2016). The research commenced in April 2013 and involved three phases of interviews – a scoping study with key informants in 2013 and two phases of interviewing in five case study areas in 2014 and 2015. In total we conducted 108 interviews for the main phases of the research reported here and 23 initial scoping interviews reported in our first interim report (Gadsby et al 2014). In addition we undertook two national surveys in 2014 and 2015 of Directors of Public Health and lead councillors for health. This final report incorporates the findings of our phase two case study research and second national surveys of Directors of Public Health (DsPH) and councillors who lead on public health issues. It also draws on the findings of the previous two phases of the research.

The research objectives set out at the start of the project were:

1. To conduct a critical analysis of the impact of recent 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).
2. To develop a clearer understanding of the relationships between different components within the public health system at national and local level.
3. To identify the ways in which organisations within the public health system approach the establishment and/or commissioning of health improvement interventions (by focusing on their approaches to tackling obesity).
4. To examine commissioning decision-making processes within case study sites, with regards to obesity/weight management activities, to identify influences on decision-making and relational influences on health improvement.
5. To identify difficulties and opportunities facing actors within the new public health system in progressing the public health agenda, and specifically in relation to preventing/managing obesity.

The changes brought about by the HSCA12, and the implications for the organisation and delivery of the public health function, have been profound. Examining the impact of such changes through research has been extraordinarily challenging, particularly given the broader changes to the health and social care system, and indeed, to other government policies in areas of education, welfare and so on. Our research points to the importance of systems thinking. The use of the term 'the public health system' to describe what in reality is "a chaotic, sprawling, dynamic set of practices which are often intensely political, and a set of activities that might more closely resemble a non-system" is inherently problematic. However, systems thinking focuses on inter-relationships, and emphasises holistic thinking from multiple perspectives.

As expected, in earlier phases of the research we found that local authority (LA) public health teams were largely preoccupied with developing the structures and processes required for effective

operation. However, our findings demonstrate that this concern with structures and organisation continued even after two years. This has involved re-thinking the skills and skill mixes required, with several of our case study public health teams concentrating on bolstering their business management/commissioning skills, and concentrating less on more 'traditional' public health skills. Financial insecurity created additional problems with LAs sometimes unsure of the details of their financial settlement from government until after many contracts had been negotiated, leaving them with few areas in which to make cost savings. In addition, budget cuts across other departments within LAs also brought additional pressures to public health teams, as costs were transferred and cuts shared across departments.

Within LAs, contracts have received new scrutiny, and both existing and new contracts have had to be negotiated with providers, within a new provider landscape. In addition, actors within the system had to negotiate ways of working with other actors, in a situation where much was new. The situation in two-tier council areas created additional complexities of inter-organisational working (discussed in the next section). The organisational position of the public health team and the director were important in terms of ability to influence strategic decision-making and work with other departments. System co-ordination also remained an area where roles and responsibilities were not clear. LAs are developing their leadership role, but there is little evidence to suggest that Health and Wellbeing Boards (HWBs) are undertaking a system co-ordination role or prioritising public health issues. We also identified a mismatch between the rhetoric at policy level which emphasises the importance of prevention and the reality, which has seen cuts in public health funding and criticism of national policy makers to take positive action on key potential 'system-level' levers for change favoured by much of the public health professional community. Our data also suggests that the public health profession has lost some of its independence and authority in terms of being able to speak out on key issues where their views are at odds with LAs or national government policies.

Whilst there has been frantic activity around the re-organisation of systems, structures and processes, which have had important consequences for role, relationships and functions, we have not necessarily seen any real shift in subsequent priorities and strategies. Actors in the new system continue to negotiate relationships with each other in terms of public health delivery. There is a continuing dynamic introduced as public health services are decommissioned and re-commissioned by local authorities. In addition the relationship between public health departments and Clinical Commissioning Groups (CCGs) remains unclear in many areas, with concerns remaining about the range and type of support provided by public health to CCGs.

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There was some evidence that approaches to tackling obesity were changing with a recognition of the need to work towards a more holistic approach to obesity services and the need to tackle the wider determinants of health. Some of our sites were developing a 'whole council' or system-wide' strategic approach reflecting the emphasis in national policy documents. However, gaps in pathway and tier provision, further funding cuts and a lack of partnership working in some areas, (either through programme provision, organisations or with district councils), were hampering this approach. It was clear that having councillor and senior officer support could have a significant impact in terms of programmes being protected or commissioned.

Our research only provides a limited overview of the development of the public health system in England between April 2013 and the end of 2015. However, our findings have highlighted some important issues that have both policy and practice implications.

- Support for a stronger LA role in public health was widespread but how the public health function and responsibilities were being developed varied considerably. We found distinct differences between authorities and there was no one specific factor that led to such differences.
- The system continues to be in a substantial state of flux. This was due to the initial degree of fragmentation and complexity in the commissioning and provision of public health services introduced in 2013, and some continuing confusion about organisational responsibilities in terms of commissioning (eg the obesity pathway).
- Financial constraint has had an impact on the capacity of public health teams - how they were organised and their position in local authority structures. Coupled with broader financial constraint in local government, the impact of budget cuts led to continuing restructuring and organisational change. It is likely that this state of flux will continue in the near future, limiting capacity and ability to fulfil all demands being made on public health teams.
- Since 2013, there have been changes in responsibility for commissioning some aspects of public health services and substantial re-organisation both in PHE and in local government.
- Two-tier councils faced particular challenges in co-ordinating public health activities and there remain problems in supporting CCGs.
- Competing policy initiatives have also led to local authorities, and particularly HWBs, focusing on specific government initiatives such as the Better Care Fund, at the expense of broader health and wellbeing improvement.
- Our findings suggest that while LAs had recognised the importance and value of public health, service integration and funding have dominated joint working agendas. There was an ongoing struggle between local agendas (e.g. tackling inequalities) and a central government push (e.g. towards integration) where HWBs can only be a part of the solution; this suggests that HWBs may be best focused on their local system oversight and co-ordination roles.
- Reductions in resources and financial constraint were forcing some local systems to examine novel approaches to commissioning and provision which has not facilitated joint working. However, our research has shown that budgets were being used flexibly at a local level. In some cases, this led to innovative use of resources, but in other areas, concern was expressed about misuse of public health funding.
- We found that other departments in local authorities were responding in different ways to having a public health resource, and there are examples of collaborative working developing in areas such as planning. Conversely, working with CCGs and the NHS remained a key concern with some public health teams struggling with capacity and in some areas poor linkage between CCGs and public health.

Overall our research suggests that the development of the new public health system in England is still in progress with both the internal organisation of public health in local authorities LAs, the NHS and Public Health England (PHE) very much in a continuing state of flux. In LAs in particular, the

additional organisational upheaval that has been a feature of local government has had a significant impact on the way the organisation of the new public health function is developing. A key message emerging from our research is that the HSCA12 and associated policies paid insufficient attention to the nature and quality of relationships across the various organisations and individuals that constitute the new public health system in England. Consequently, whilst some of the challenges identified during the passage of the health and social care bill have been averted, many remain. And whilst some of the opportunities identified have been realised, many are highly dependent on a range of locally contextual factors, and most are simultaneously threatened by conflicts and negative feedback loops within the system.

1. Introduction

1.1 Background

The public health system in England has undergone substantial reorganisation with a wholesale transfer of public health responsibilities from local NHS organisations to local authorities (LAs) and to Public Health England (PHE) – an organisation created in 2013 which subsumes a large number and wide range of former bodies. At the same time, health service leadership and commissioning were transformed through the creation of NHS England (NHSE) – at ‘arm’s length’ from Government – and Clinical Commissioning Groups (CCGs). These structural changes have had enormous implications for the way in which the public health function is approached, organised and delivered. Outside the clinical arena, the key responsibility for improving the health of local populations, including reducing health inequalities, rests with democratically accountable upper tier and unitary LAs. However, under the new system, the NHS has remained critical to protecting and improving the population’s health. It is charged with delivering certain public health services, and with promoting health through all its clinical activity.

1.2 Aims and research objectives

The PHOENIX project examined the impact of these 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 research was carried out by the Policy Research Unit on Commissioning and the Healthcare System (PRUComm), which is directly funded by the Department of Health (DH). It was a 33-month study, commencing in April 2013.

The study explored the impacts of structural changes at national, regional and local levels on the planning, organisation, commissioning and delivery of health improvement services. Taking obesity as a tracer topic, it examined the response of local public health systems to this issue: the approaches taken by key actors; how commissioning decisions were being made; what the resulting spectrum of services/activities looks like; and whether there was any change in the balance of services commissioned or carried out. The project sought to identify the extent to which, how and why key opportunities within the new system were being realised; key challenges are being overcome; and key concerns are addressed. The research objectives set out at the start of the project were:

1. To conduct a critical analysis of the impact of recent 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).
2. To develop a clearer understanding of the relationships between different components within the public health system at national and local level.
3. To identify the ways in which organisations within the public health system approach the establishment and/or commissioning of health improvement interventions (by focusing on their approaches to tackling obesity).
4. To examine commissioning decision-making processes within case study sites, with regards to obesity/weight management activities, to identify influences on decision-making and relational influences on health improvement.

5. To identify difficulties and opportunities facing actors within the new public health system in progressing the public health agenda, and specifically in relation to preventing/managing obesity.

The changes brought about by the reforms are profound, and carry both potential opportunities and risks. The many concerns raised in the early days of the reform process have been written about elsewhere (see Gadsby et al 2014; Riches et al 2015; Coleman et al 2013; LGIU 2012). Whilst many commentators have noted that the changes to the public health system were welcome, there is widespread consensus that the timing was difficult, with the financial context for local government presenting huge challenges. LAs were given little prescription about how to organise and deliver their public health functions. Given the variety in structure, political administration, and organisational culture of LAs in different parts of the country, local public health systems have developed in a variety of ways. It has been very interesting to investigate *how* these local systems were developing, in the context of systemic changes at regional and national levels.

This report is the fifth and final report for the project. It should be considered alongside a first interim report (Gadsby et al 2014), focusing on our scoping study phase; a second interim report (Peckham et al 2015) focusing on our phase one case study research and first national survey; a first survey report (Jenkins et al 2015) and a report of the second survey (Jenkins et al 2016). This final report incorporates the findings of our phase two case study research and second national surveys of Directors of Public Health (DsPH) and councillors who lead on public health issues. It also draws on the findings of the previous two phases of the research.

1.3 Policy Context

A large number of policy, guidance and other documents have been produced since the DH's 2010 White Paper 'Equity and Excellence: Liberating the NHS', which laid out the original Health and Social Care Bill intentions. Those that were particularly pertinent to the organisation and delivery of the public health function when we commenced our case study research in 2014 are listed in Table 1.

The Health and Social Care Act 2012 (HSCA12) was introduced by the Conservative/Liberal Democrat coalition government that identified their "most urgent task" as tackling the national financial deficit (HM Government, 2010: 7). The state of the public finances, together with rising demands and costs in the NHS, helped to trigger the multiple changes to the health and care systems (DH 2012a). In addition, international comparisons highlighted the need for improvement in many areas of disease prevention and management, and it is well recognised that there are many opportunities to improve population health and wellbeing by taking effective action on 'preventable' mortality (DH 2013a). Prior to the 2013 reforms, the public health system was seen as fragmented, with not enough synergies across services and inefficiencies due to overlapping responsibilities (DH 2012b). Public health activities (particularly in terms of health improvement) were felt by the government to be having limited impact on the health of the public.

Due in part to the fragmented nature of the public health system, it was felt that there was limited accountability with regards to outcomes prior to the HSCA12. The public health White Paper (DH 2010) set out a vision to bring about a greater emphasis on disease prevention, a greater focus on 'what works', and to achieve better results with less money. The White Paper set out a vision that

Table 1: Policy, guidance and other documents of most relevance to the public health system

Jul 2010	The government published 'Equity and Excellence: Liberating the NHS' –white paper that laid out the original Health and Social Care Bill policy intentions, and set out the intention to strengthen the role of local government in local health services.
Jul-Oct 2010	More than 6000 responses received to the government's consultation on 'Liberating the NHS'
Nov 2010	The government published 'Healthy lives, healthy people: our strategy for public health in England' – white paper that set out the government's long-term vision for the future of public health in England and its aim to create a 'wellness' service (PHE) and to strengthen both national and local leadership. The paper made it clear that "local government and local communities will be at the heart of improving health and wellbeing for their populations and tackling inequalities."
Dec 2010	The government published its full responses to the consultation on 'Liberating the NHS'
Jan 2011	Health and Social Care Bill 2011 introduced in the House of Commons
April 2011	The government announced a 'pause' in the legislative process and launched NHS Future Forum as part of the government's listening exercise on the Health and Social Care Bill.
Jun 2011	NHS Future Forum published key recommendations followed by the government response to the report.
Jul 2011	The government published 'Healthy lives, healthy people: update and way forward', a policy statement which reaffirmed the government's vision for a new public health system. It set out the progress made in developing the vision for public health, and a timeline for completing the operational design of this work through a series of Public Health System Reform Updates.
Jul 2011	Organisations representing the membership of HWBs published 'Operating principles for HWBs: Laying the foundations for healthier places' to support their effective establishment and functioning.
Autumn 2011	Resumption of the passage of the Health and Social Care Bill.
Dec 2011	DH published the 'Accounting officer systems statement' which outlined current and future accountability for public health, focusing on the period after April 2013.
Jan 2012	DH first published 'Introduction to the Public Health Outcomes Framework 2013-2016', which all LAs "must have regard to" in the exercise of their public health functions.
Mar 2012	Health and Social Care Bill received royal assent.
Jun 2012	DH published 'Health and Social Care Act 2012: fact sheets', explaining aspects of the Act. One of these was titled 'New focus for public health fact sheet'. These were updated versions of the fact sheets first published in October 2011.
Jun 2012	The government published 'Healthy Lives, Healthy People: Update on public health funding', aimed at public health specialists, setting out current thinking on LA public health finance.
Jan 2013	DH first produced a LA circular 'Ring-fenced public health grant conditions', setting out the conditions for using the money. A range of associated documents then followed, detailing the allocations, reporting arrangements, and funding formula.
Mar 2013	The House of Commons Communities and Local Government Committee published its eighth report of session 2012-13: 'The role of local authorities in health issues', together with minutes and evidence from 40 written submissions and 5 oral evidence sessions.
Mar 2013	DH published 'Living well for longer: a call to action to reduce avoidable premature mortality', directed at the health and care system nationally and locally, primarily focusing on the 5 biggest killer diseases (cancer, stroke, heart, liver and respiratory disease).
Mar 2013	PHE published 'health and wellbeing: introduction to the directorate', setting out the programmes, priorities and approach of the health and wellbeing directorate of PHE.
March 2013	DH published statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.
April 2013	Reforms to the health service and commissioning arrangements came into effect.
April 2013	PHE published 'our priorities for 2013/14'.
May 2013	The government published 'Healthy lives, healthy people: a public health workforce strategy', which set out actions for various partners in the new public health system to support and develop the public health workforce. "It will help embed public health capacity within the wider workforce to support delivery of the public health outcomes framework".
Jul 2013	The government published its response to the House of Commons Communities and Local Government Committee report on the role of local authorities in health issues.
Nov 2013	The government published 'Framework agreement between the Department of Health and Public Health England', defining how they will work together, and how they will discharge their accountability responsibilities. The framework was issued in conjunction with PHE's Code of Conduct.
Feb 2014	House of Commons Health Committee published its eighth report of session 2013-14 on Public Health England, together with formal minutes relating to the report.
Jun 2014	Letter from Parliamentary Under Secretary of State for Public Health to Chief Executive of PHE, setting out the role that the Government expects PHE to play in the health and care system.
Oct 2014	Five Year Forward View sets out how the NHS needs to change.

led to a number of fundamental changes to the structures and organisation of public health systems in April 2013. Enacted by the HSCA12 the new public health system in England was established in order to: increase the emphasis on public health and disease prevention; create a more joined-up system with clearer leadership; and have a greater impact on the wider determinants of health at local level.

At national level, by abolishing several public health organisations (including the Health Protection Agency) and creating PHE as the new 'integrated' public health service, the government aimed to create an 'authoritative voice' on all public health issues, providing a better co-ordinated system (DH 2014). It was argued that by containing the functions of multiple organisations within one new national agency, they would reduce overlapping responsibilities, reduce inefficiencies, and exploit synergies across services. By bringing together the knowledge and intelligence into one organisation, it was hoped that PHE would provide LAs, the DH and the NHS with clear advice and evidence on what works best in protecting and improving public health.

At local level, by putting LAs in charge of driving health improvement, the government established LAs as lead organisations in improving health and coordinating local efforts to protect and improve the public's health. The government hoped that strong local political leadership and better integration between health, social care and public health, would lead to a community-wide approach to protecting and promoting health and wellbeing. This was expected to realise greater opportunities and efforts to tackle the wider determinants of health at local level, as well as tackling the individual and behavioural determinants. LAs were expected to take a broad view of what services will impact on the public's health, and to combine traditional 'public health' activities with other activity locally to maximise benefits (DH 2012b). The HSCA12 also gave LAs a statutory duty to create a Health and Wellbeing Board (HWB). HWBs were intended as a forum where key leaders from the health and care system work together *"... to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future"* (DH 2012c).

In moving Primary Care Trust (PCT) public health resources and functions from the NHS to local government, the government was aiming to achieve strengthened relationships between public health professionals and LA personnel in all departments so that public health could be 'embedded' within all LA work to more fully address the wider determinants of health at a local level. The Director of Public Health (DPH) is the lead officer in a LA for health, and is expected to champion health across the whole of the authority's business. Elected members and other senior officers are expected to consult the DPH on a range of issues, from emergency preparedness to concerns around access to local health services.

The government created a temporary ring-fenced public health budget which was to be given by PHE to LAs¹. Because the grant is no longer part of a single funding allocation to provide health and public health services, it is now possible to routinely collect full data on public health spending. This

¹ The public health grant was initially ring-fenced for 2 years, which was extended for an additional year to April 2016 and subsequently to 2018.

was intended to aid comparison between areas. By setting out six functions that LAs must have in place, the DH hoped for greater uniformity of services. These mandated functions are:

- appropriate access to sexual health services
- steps to be taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- the National Child Measurement Programme
- NHS Health Check assessment.
- Child health programme 5-19

However, LAs have discretion over how best to spend the grant to achieve better local public health outcomes. Since LAs are responsible to their electorates for those decisions, the government envisaged that local democratic accountability would be strengthened.

Finally, the creation of a public health outcomes framework was intended to help shift the focus from processes to outcomes. The framework concentrates on two high-level outcomes to be achieved across public health system, and groups further indicators into four 'domains' covering the whole range of public health. The outcomes look at how well people live throughout their life stages. The baseline period is 2010 or equivalent, unless these data are unavailable or not deemed to be of sufficient quality. Data are published as part of a quarterly update cycle in August, November, February and May².

It was also intended that local public health systems would be assessed using the indicators in the framework. This would enable transparency and an element of comparability between different local areas, for accountability by the centre, but also for sector-led improvement-style accountability. However, it was not envisaged that the outcomes framework would be a performance management framework by which central government holds the different elements of the public health system to account, but rather a framework to set the strategic direction and context for the effective delivery of public health services by PHE, LAs and the NHS providing benchmarking and monitoring data.

1.4 Perceived system opportunities and challenges

At the beginning of the research we conducted a number of scoping interviews with key national stakeholders, reviewed the key policy documents and undertook an analysis of the evidence submitted to the Communities and Local Government Select Committee Inquiry into the shift of public health into LAs (Gadsby et al 2014, Riches et al 2015). This produced a series of perceived opportunities and challenges, organised according to different aspects of the public health system (informed by van Olmen et al's 2012 model), summarised in Table 2. These provided a context for our research and we have covered a number of these areas in the findings presented in this report.

² The most up-to-date data set can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496417/Table_of_PHOF_up_dates_February_2016.pdf

Table 2: The public health system – perceived opportunities and challenges

	Key opportunities	Key concerns
Leadership and governance	<p>Transfer of responsibility for many public health functions to local government – potentially stronger leaders of local public health system.</p> <p>New and centralised agency – PHE – at ‘arms-length’ from government.</p>	<p>Some LAs may be slow to realise the full extent of their public health responsibilities across all 3 domains of public health – particularly in areas where they are less familiar, such as health protection and sexual health services.</p> <p>With public health moving arms-length to the NHS, their advice and influence may wane.</p> <p>Narrow incentive system based on central measures of performance may fail to take into account that there are multiple influences on the health choices individuals make.</p> <p>Lack of clear lines of accountability and communication for protecting and improving the health of the local population.</p> <p>Loss of independence for the public health workforce to challenge powerful interests whose actions risk the health of the population.</p> <p>Confused and complex lines of accountability and responsibility between the various bodies involved in the commissioning process.</p> <p>Some DPH posts (particularly in London) remain unfilled, or filled with temporary appointments. This may affect both continuity and strategic influence.</p>
Structural capacity	<p>Information: Possible new opportunities for shared intelligence within local government</p> <p>Organisational resources (including networks, partnerships, collaboration): Restructuring might provide opportunities for creativity in combining public health and council functions.</p> <p>Within local government, public health networks might offer new opportunities for collaboration, including shared services,</p>	<p>Information: The work of existing public health networks may be lost. Public health intelligence may be fragmented.</p> <p>Organisational resources (including networks, partnerships, collaboration): LAs will provide a very different culture from PCTs – both councils and PH will need to adapt to each other. Different areas have different starting points in terms of the extent of joint work between public health and LAs – this will influence how far and fast changes are made.</p> <p>There may be areas of potential duplication, e.g., with the Local Area Teams (LATs) and with Commissioning Support Units (CSUs).</p> <p>Public health departments within LAs may be responsible for completely different</p>

	<p>intelligence and analysis and cross-authority public health commissioning.</p> <p>Human Resources: Potential for greater health improvement through embedding public health expertise in LAs – possibly improving potential to influence distal social environments.</p> <p>Fiscal Resources: Ring-fenced budget for public health offers some financial security.</p>	<p>populations than those of CCGs (limiting their potential health services public health input).</p> <p>Public health departments within LAs are unlikely to be able to establish effective or efficient working arrangements with market-based CSUs (who will also be providing input into health services planning).</p> <p>Concerns about loss of regional structure, and how PHE will cope (incorporating the functions of about 70 former bodies).</p> <p>Reforms may not encourage the right behaviours between the NHS and local government. E.g., driven by budget pressure, both might withdraw from key prevention services, claiming the other is funded for the work.</p> <p>Human Resources: Lack of clarity as to how professional standards will be maintained for staff who will undertake the public health functions that are moving out of the NHS system.</p> <p>Fragmentation of the public health workforce, limiting opportunities to share scarce skills, maintain and develop capacity and assure competence.</p> <p>Loss of public health staff during the transition period.</p> <p>LAs may not be adequately resourced or appropriately staffed to carry out their new duties.</p> <p>Fiscal Resources: Concern that budget allocations to LAs will be insufficient to meet responsibilities and aspirations. With overall resources for local government being squeezed, the 'ring-fenced' public health budget may be pulled more broadly and redistributed for activities other than originally intended.</p> <p>There is no long term guarantee that budgets from the NHS will flow to local government in adequate volume to cover Local Government's new public health functions and services.</p> <p>About 1/3 of the allocated public health budget is connected to mandated services. The remaining 2/3 will be prioritised according to local need. (Obesity services are not covered by the mandating regulations).</p>
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Outcomes and Goals	Stand-alone public health outcomes framework.	<p>The changes could increase rather than reduce health inequalities (fragmentation of services, greater local diversity, more locally managed commissioning).</p> <p>The changes could also increase inefficiencies.</p> <p>Competition could lead to compromises in quality and integration.</p> <p>Question mark over precise status of the national outcomes frameworks given the government's commitment to localism.</p>
Values and principles	Increased focus on life-course approach:	Concerns were raised about there being no guarantee that the services being transferred to local government will continue to be a universal NHS entitlement, free at the point of use (although the 'strengthening' of the NHS constitution gives some assurance for now).
Population	Opportunities for greater engagement with communities, people who use services and carers through the move of public health to LAs and the development of local healthwatch.	Persistent (and widening) health inequalities and worsening of indicators around non-communicable diseases and 'lifestyle' issues.
Context		<p>Threat to integrated patient care from unnecessary competition.</p> <p>Wider context of austerity measures - other government reforms, particularly to welfare programmes, may adversely affect health and wellbeing, adversely affect particular vulnerable groups, and further increase inequalities.</p>
Public Health Practice	<p>Greater potential to address wider social determinants of health through the full range of local government functions and partnerships.</p> <p>Potential closer working and integration of health and social care, so that people's needs are recognised and responded to in a holistic way.</p> <p>Public health 'responsibility deal' for</p>	<p>With public health moving arms-length to the NHS, providers may become less embedded within the local public health systems.</p> <p>Some wellbeing services could end up being disconnected from each other and from wider support. E.g., smoking cessation services may have no clear protocol to refer to enablement support such as assistive technology or to support for carers.</p> <p>The split responsibility for children and young people's public health between NHSE and local government could lead to fragmentation of planning and provision.</p> <p>In some cases, the shared or split responsibilities for commissioning of services are</p>

	<p>businesses to be more involved in tackling the health-related impacts of food, alcohol, physical activity and the workplace.</p>	<p>extremely confusing.</p> <p>There is a real risk of duplication and confusion if, for example, PHE is accountable for health protection in some circumstances and LAs in others.</p> <p>Failure to recognise the health service domain of public health and create explicit mechanisms for public health input and advice to the commissioning and provision of healthcare services.</p> <p>Considerable discretion is being afforded to individual LAs to interpret the full and detailed scope of their new functions and services.</p>
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1.5 The structure of the report

This final report summarises the findings of the case study research and supplementary regional and national level interviews which took place from March 2014 until September 2015, second national surveys of both Directors of Public Health (DsPH) and councillor leads for public health undertaken in September 2015. In examining the findings of the second national surveys, analytic comparisons are drawn with the first surveys conducted a year earlier. Accompanying this report is a separate more detailed report focused on the second surveys (Jenkins et al 2016).

In section two we describe the methods used in the research, and give an overview of our case study sites. All efforts have been made throughout the report to preserve the anonymity of the sites and individual interviewees, so descriptive detail is limited. In section three, we briefly set the scene by discussing how different elements of the public health systems have developed since April 2013. This section provides a backdrop for a more detailed discussion of relationships within councils in section four, and between different organisations across the systems in section five. Section 6 looks at health improvement activities specifically for obesity prevention and weight management, and the report ends with a discussion and conclusion in section 7.

2 Methods

2.1 Overall research design

The study took an exploratory approach and incorporated multiple methods, including key informant interviews, document analysis, local case-studies and national surveys. We conducted an initial scoping review in the first nine months (from April 2013) which we used to frame the focus of our data collection in subsequent case study research. During this stage, we conducted 22 semi-structured interviews at national, regional and local level (see Gadsby et al 2014 for further details), and analysed policy documents and stakeholder organisations' written responses to consultations on the reforms. We also conducted a detailed analysis of the Select Committee report into the role of LAs in health issues (see Riches et al 2015). This scoping review identified a number of key areas that provided a framework for the subsequent phases of this research. These related to the governance and accountability mechanisms for public health, local decision making processes, different ways of working and the need to develop new relationships to work in a more fragmented public health system (Gadsby et al 2014).

Ethical approval was obtained from the University of Kent Research Ethics Committee (SRCEA No. 112), and research governance approval was obtained for each case study site in respect of NHS interviewees from the Health Research Authority (15 July 2015/182754).

2.2 Qualitative case studies

In order to explore the research questions in detail we identified a range of key criteria for selecting case study sites (whether upper or lower tier, unitary or county and district, size, etc.), that would enable us to investigate relational aspects within LAs and between LAs and other public health agencies and stakeholders (e.g. CCGs, PHE, NHSE). Recruitment of case studies commenced in December 2013 with the aim of obtaining a mix of up to eight authorities with geographical spread, varied socio-demographic and socio-economic contexts and different political control. We collated key organisational and demographic data for all 152 upper-tier and unitary authorities in England and from that database we purposively selected 11 councils (See Peckham et al 2015 for details of case study selection criteria) and wrote to the relevant chief executives/leaders and DsPH. Five of our targeted authorities declined to participate, and one did not respond.

Research in those case study sites that agreed to participate commenced as soon as research ethics and governance approval was granted. It became clear in the authorities where we were already working, that the public health organisational landscape was evolving quickly. We quickly identified a range of complex joint arrangements for public health. In county case studies, the important role of district councils was immediately obvious. We felt it was imperative that the research captured this aspect of the new system and explored the district/county council relationships. In other case study sites, there were a range of organisational arrangements between authorities including joint appointment of DPHs, shared public health teams, formal inter-authority collaborations and agency arrangements where one LA acted on behalf of another. These are not all discrete developments with some case study sites displaying a number of different relationships. In addition to these inter-

authority relationships, each case study had a range of differing relationships with CCGs, service providers and regional and national public health and NHS agencies.

This complexity was important in terms of exploring relational and organisational issues and how LAs developed their commissioning and delivery systems for public health. As a result, it was decided to halt recruitment of further case studies. We decided to focus our research on five case studies and develop a more in-depth exploration of these areas to include relevant adjacent authorities and the broader context within which public health was developing in these areas. This resulted in the inclusion of a sample of district councils within county council areas, adjacent unitary/county authorities where there were county links, extended data collection to the supra-network and the inclusion of adjacent authorities sharing a DPH. Within our five case study areas, we included nine upper-tier or unitary authorities, and a sample of four lower-tier councils. In each case study area, the focus has remained on the initial council, but with additional interviews in the other authorities to explore the organisational relationships and collaborative approaches being developed. This approach enabled a much richer analysis of current developments related to organisation of public health and a clearer picture of the emerging public health system structures to be identified. The overview of case study sites is shown in Table 3.

Table 3: Overview of case study sites

Site	Final case studies
A	County council including sample of 2 different sized district councils and adjacent unitary authority
B	Cluster of three urban unitary authorities with shared DPH
C	Urban metropolitan unitary authority
D	County Council including sample of 2 different sized district councils and unitary councils
E	Urban metropolitan unitary authority working with network of other urban unitary authorities

We began the case study phase of the research in March 2014. This first phase of case study work focused on exploring:

- how public health activities are organised/arranged in the LAs;
- where, how and by whom formal decisions are made about public health needs, priorities and strategies;
- what influence PHE has on local public health decision making;
- the nature of relationships between LAs and CCGs, and between LAs and other external organisations;
- the extent to which there is a shift in approach or a move towards new ways of working across the local public health system.

In December 2014, we paused our data collection in order to consolidate our primary analyses and write an interim report (see Peckham et al 2015). In March 2015, we embarked on the second phase of work, which continued until September 2015. This second phase took us beyond our examination of the wider structures and organisation of public health at a local level, to examine in further detail how public health teams were working with other directorates such as education and planning, using obesity as a tracer topic. We were interested in examining the response of the local public health systems to obesity as an example of a ‘wicked problem’ (Rittel and Webber 1973, Hunter 2013). We focused on exploring:

- How organisations approach the establishment and/or commissioning of healthy weight interventions (who is involved? Who is leading? Who is accountable to whom? Who provides what resources?);
- What key commissioning decisions have been / are being made in relation to obesity (what has been prioritized (and not prioritized) since the reforms? Why?)
- What difficulties / opportunities actors have faced in the new system in progressing obesity prevention/weight management?

2.2.1 Case study descriptions

Site A:

This site encompassed a large two-tier council, with multiple districts and CCGs. The upper-tier council was Conservative-run, covering a heterogeneous population that as a whole was within the least deprived third of authorities (in England), but which contained pockets of severe deprivation. The county council was run by a leader and a cabinet, who together comprised the ‘executive’, and who appointed a corporate management team representing the main directorates. The HWB was chaired by a cabinet member and included elected members from three of the county’s districts.

The public health team transitioned into the Council in 2011, although the DPH had been a joint appointment for several years before that. The team were located in one place in the council, as a separate department. However, in subsequent re-organisations, that department was situated within a new directorate covering social care, health and wellbeing. The public health team comprised over 50 full-time equivalent staff. They were organised by function, but had a nominated consultant lead for each CCG - each CCG area also had a local HWB, a specialist lead for each district council, and leads for each county council directorate. Due to the importance of local links and geography, data collection in this site was expanded to encompass a neighbouring (also Conservative) unitary authority, with which there was a strong history of joint working, and a sample of two district councils.

Site B:

This site was focused on an urban borough council with a Conservative majority. The borough has a relatively young, relatively healthy population (compared with England as a whole), but areas of great affluence sit alongside pockets of deprivation. Due to financial pressures, the council combined specific areas of service delivery with neighbouring councils. Public health was one of those combined services, being hosted by one borough, but working across the other boroughs. The

council was run by a cabinet, supported by a chief executive and other strategic directors who together formed the Strategic Executive Board. The public health team was located in one place, and were structured according to function. They had one strategic DPH and three Deputy DsPH. The team were initially placed within the Chief Executive's division, but were moved into the Adult Social Care Services directorate. There was a separate HWB in each of the boroughs. Due to the nature of the sharing arrangement, whilst our focus was on the one borough chosen, we expanded our data collection, to some extent, to include the other boroughs.

Site C:

This site had a large urban population ranked very highly in terms of overall deprivation. It was particularly disadvantaged in relation to employment, income, education, skills and training. Men and women living in site C have had a shorter life and healthy life expectancy than the national average. The unitary council was Labour-led and had two parliamentary constituencies. The DPH reported to the chief executive in the council and the public health team (comprising 20 staff) were in a community orientated directorate, encompassing adult social care, education, children and families, among other responsibilities. Prior to the reforms, there was a good history of joint working between the PCT and the council, with a jointly-appointed DPH. The one CCG that was initially linked to the council merged with a neighbouring, larger CCG during the course of the research. There was one HWB, chaired by a councillor.

Site D:

Site D incorporated a two-tier county council, with a number of district councils in the lower tier, and two neighbouring unitary councils. Income levels were generally above the national average, but there were pockets of deprivation within the county. The county council was Conservative-led, with five departments overseen by a chief executive. The DPH oversaw their own directorate, and was managed directly by the chief operating officer. The public health team (totalling more than 35 members of staff) grew in size number following the inclusion of some provider functions from other parts of the council.

The county council worked closely with the neighbouring city council, and with a small neighbouring unitary authority, where the county public health department acted as an agent for the council. These three LAs had a joint health overview and scrutiny committee to scrutinise the work of the health services that work across the three authorities. The County Council's HWB was chaired by the lead member for health; two district councillors sat on the HWB to represent all district council interests. Each of the districts had their own non-statutory HWB partnership groups. The County HWB often dealt with issues across the wider healthy economy that encompassed the three LAs. Across this wider health economy, there were three CCGs, two of which covered the county area.

Site E:

This site was a unitary authority in a large city with high levels of deprivation which were almost universally above the national average for all areas of the city. The authority was Labour-led with no major opposition. The council operated a committee structure, with the Executive as the principal decision making body. The leader of the Executive was also the chair of the HWB.

The council was organised with six directorates overseen by a chief executive. Public health was not established as a standalone directorate and following a restructuring process by the authority, it became part of the directorate responsible for children and families. The public health team also underwent a period of restructuring resulting in a core of public health team practitioners reporting to and supporting the DPH each being responsible for a particular function. Public health staff numbers have reduced and the team eventually consisted of around 30-40 members. There were multiple CCGs. There was a successful collaborative network that worked across the LAs in the wider area, on behalf of the DsPH.

2.2.2 Data collection within case study sites

In our case study sites, we have conducted 103 interviews with a purposively selected sample of personnel from within the public health teams, from within the councils (both officers and elected members), from HWBs, and from other commissioning and providing organisations (see Table 4).

Table 4: Interviews conducted (not including scoping stage)

	Site A	Site B	Site C	Site D	Site E	Totals	Plus non-site specific
Total interviews	23	13	23	22	22	103	5
Total interviewees	22	11	24	22	22	101	5
Council public health staff	8	8	9	5	6	36	-
Council elected members	7	1	4	3	3	18	-
Council non-PH staff	3	1	6	9	6	25	-
Provider organisation staff	4	1	2	3	3	13	-
CCG staff	0	0	2	1	3	6	-
Other (regional)	0	0	1	1	1	3	-

Directors of Public Health and the councillor with the health/public health portfolio were interviewed in all sites. We examined committee meeting documents and organisation websites and used snowballing techniques to identify participants, whereby we asked existing participants to facilitate access (by way of introduction) to others, where appropriate. We attended relevant public meetings in order to identify and/or 'meet and greet' potential participants. We usually made initial

contact by email, and if no response was obtained, we re-issued our request up to three more times. In some cases, despite working hard to gain access to a representative from a particular organisation or council department, we were unable to secure an interview (for instance, in case study site A, where we were unable to secure an interview with anyone from a council planning department or CCG).

Interviews were semi-structured and varied in length from half an hour to over two hours, with most lasting approximately one hour. Interview guides were constructed for key 'groups' of people (e.g. DsPH and public health consultants, elected members, programme managers/practitioners, those in other council departments, and those in other organisations). Interviews followed a period of desk-based research for each case study area, where organisation websites, meeting minutes and key documents were reviewed and analysed to create a 'story' for each case study site that was continually 'fact-checked', reviewed and updated during the course of the research. In each interview, we explored the participant's background and history in relation to their role and the organisation. The first wave of interviews tended to focus on the processes of transition and on developing a picture of the roles, responsibilities, structures, mechanisms and relationships within and between elements of the new system. The second wave of interviews tended to focus on further examining those roles, responsibilities, structures, mechanisms and relationships, but in relation to how obesity was approached in each case study area. When examining how obesity was approached, we focused on three broad areas of work, identified to enable us to examine key relationships: 1) the obesity pathway, which examines in particular the interface between the NHS and LAs; 2) obesity prevention in schools, which includes relationships both between LA departments (public health and education) and between LAs and other organisations; and 3) more 'system level' interventions for the promotion of healthy eating and physical activity, e.g. through spatial and transport planning or fast food and planning.

Supplementary documents were sought and access to meetings was negotiated with participants where relevant and possible. We observed 15 meetings across the five case study sites and collated a wealth of supplementary documentary data which contributed to our knowledge and understanding of the sites.

2.3 Additional qualitative data

In addition to the case study work, we also conducted interviews with five key informants at regional and national level, particularly to explore relationships between LAs and PHE local centres, PHE and NHSE, and internal relationships within PHE between the national and local teams. These interviewees were purposively selected for their experience (for instance within multiple organisations, which afforded them rather unique perspectives), expertise (for instance with system 'design') and location within the system (to include both national and regional representatives). Interviews were recorded and transcribed, and transcripts were read and re-read. The data was used to provide national and regional context to our local data.

2.4 Web based surveys

Surveys, in the form of web-based questionnaires (using the Survey Monkey platform), were sent out in 2014 and 2015 to all of the 152 upper tier and unitary authorities in England. They were designed to make comparisons between the perspectives of professional and elected leaders of public health and to see how these changed over time. The surveys were sent to all DsPH (and, where groups of LAs shared a DPH, to the senior public health consultant in each council) and to councillors who had a public health brief (normally the cabinet member or executive lead). We constructed the questionnaire ourselves, with expert advice and guidance provided by our stakeholder group and by a LA public health consultant, and piloted them with our case study sites.

The DPH questionnaire included sections on: sharing arrangements for the public health function between authorities; experience and length of time in post of the respondent; the public health team – its size, composition, arrangement and strategic alliances; the DPH's position within the council – including line management, membership of senior corporate management team and access to elected members; the functions and responsibilities of the public health team within the council, and the extent to which the staff have become integrated into the council; roles and relationships within the council; the public health budget; relationships with other organisations; health and wellbeing boards; relationships with CCGs; changes in commissioning since April 2013 – including specifically changes in obesity and weight management services.

In 2014, the DPH questionnaire contained 44 questions, with several opportunities to include additional comments throughout, plus an additional two opportunities to add any further comments and to supply name and contact details for further information. The elected member survey was shorter, with 26 questions in 2014 with the opportunity for further comments. Elected members were asked about their experience/length of time in both the council and that role; their views about how well public health staff have become integrated into the council; roles and relationships within the council; the public health budget; relationships with other organisations; health and wellbeing boards; approaches to health improvement and main areas of activity on preventing obesity and improvement weight management. Many of the questions in the elected member survey were the same as those posed to DsPH.

We achieved a good response for the first DPH survey with 96 usable replies (63% response rate). For the councillor survey, we received 54 usable replies (36% response rate). Given the descriptive nature of the research, the threshold for a 'usable' response was set low, and all replies were kept if they supplied information we did not already know. Overall we received at least one response from 115 LAs (76%), and had both DPH and elected member perspectives in 34 (22%) authorities. There was a reasonably representative spread of DsPH responses across England in terms of region, type of authority, party in power, population size and public health budget per head. The same was true for elected members, apart from there being more replies than expected from London boroughs and less from non-metropolitan unitary authorities. Fuller details of the 2014 survey and descriptive statistics are discussed in a separate report and published paper (Jenkins et al 2015a, Jenkins et al 2015b).

The surveys were repeated in 2015, adding questions about further re-structuring and responses to budget cuts, and omitting questions that did not seem appropriate a second time. The 2015 surveys were slightly shorter, but covered the same topics. In 2015, there were 74 usable replies from DsPH (49% response rate) and 48 (32% response rate) from elected members with a health portfolio. 96 of the 152 upper tier and unitary LAs (63%) were represented in the replies, and for 26 of these (17%) both the DPH and elected member replied. Year on year comparisons of DPH responses were possible for the 59 LAs that replied in both years and for 23 LAs where the elected member replied in both years. The overall response was better in the DPH survey (with replies in both years from 39% of LAs, replies in one year from 34% of LAs and no response at all from 27%), making the DPH results and year on year comparisons more reliable than the elected member survey, where response rates were lower and a smaller proportion of authorities replied in both years. The responses overall were reasonably representative of England in terms of the spread across regions, different types of authority, the political party in power, population size, levels of material deprivation and the per capita public health budget, apart from some under- and over-representations of elected members by region. The subset of 59 authorities where we had a DPH reply in both years was a close representation of the English authorities sampled. The 2015 survey results and comparisons with 2014 findings appear in a separate report (Jenkins et al 2016).

2.5 Data analysis

All interviews were recorded and transcribed. For the first phase of case study interviews, data was coded and analysed (using NVIVO 10) for key themes. The focus and themes for analysis were drawn from the case study data as well as from the work conducted during the scoping stage. For the second phase of case study interviews, we used the same broad analytic framework. The research team wrote, compared and discussed synopses of the interview transcripts, and worked together to summarise and synthesise the data, analysing it on a case - and theme-based approach. We used multi-investigator, multi-site and multi-method triangulation in an ongoing and iterative process of bringing together and interrogating the data. The research team met (either face to face or via Skype) frequently and regularly throughout the data analysis periods.

Survey responses were mainly in the form of categorical data ('ticked box' replies) and free text comments, processed using a statistical package (SPSS). The surveys were designed to describe the national situation, so results are presented in frequency distributions and tables, and summaries of the free-text comments. Cross-tabulations were used to look for associations between replies in 2014 and 2015 and between variables in the main areas of interest, such as the nature of the LA, how the public health team was arranged and managed, relationships, influence and changes in commission for health improvement. Statistical tests (chi-square) were used where there are sufficiently large numbers for these to be valid. With the number of responses achieved in these surveys, differences in proportions of at least 10-15 percentage points are needed to be regarded as statistically significant.

For this report we are focusing mainly on data from our case study sites, however, data from the surveys and from the non-site specific interviews has been incorporated where relevant.

3 Developing the new systems

This section provides an overview of how the different elements of the public health systems have developed since April 2013. The findings presented in this section are drawn from our scoping interviews with key stakeholders and our case study data. Given the timing of our research, our data tells the story – from then until autumn 2015 - of how the different elements of the public health system ‘settled in’ (in terms of establishing roles, positions and relationships) and ‘sorted out’ (in terms of contracts, budgets and responsibilities). This section provides a backdrop for a more detailed discussion of relationships within councils (section 4) and between different organisations across the local public health systems (section 5).

3.1 Developing the organisational architecture

The changes to the organisational architecture brought about by the reforms are comprehensive and radical. In summary the reforms have seen (DH 2011b):

- LAs taking the lead for improving health and coordinating local efforts to protect the public’s health and wellbeing, and ensuring health services effectively promote population health.
- A new executive agency, PHE to:
 - deliver services (health protection, public health information and intelligence, and services for the public through social marketing and behavioural insight activities)
 - lead for public health (by encouraging transparency and accountability, building the evidence base, building relationships promoting public health)
 - support the development of the specialist and wider public health workforce (appointing Directors of Public Health (DsPH) within LAs, supporting excellence in public health practice and bringing together the wider range of public health professionals)
- The NHS continuing to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts.
- The Government’s Chief Medical Officer continuing to provide independent advice to the Secretary of State for Health and the Government on the population’s health.
- Within Government, the DH setting the legal and policy framework, securing resources and making sure public health is central to the Government’s priorities.

The ease with which public health staff and resources were transferred into LAs was very varied. Importantly, the transfer often involved more than just transferring a team of staff from one organisation to another. Frequently, there were other reorganisations – either mergers, the splitting up of jurisdictions, or cuts in staff numbers – happening simultaneously. For instance, in one of our sites, where there were two former PCTs, the public health responsibilities (and staff and resources) were merged into one council department. Meanwhile, the clinical commissioning responsibilities (and staff and resources) were split between more than five new CCGs. Knock-on changes also occurred in the creation of one large community NHS trust, which merged the provider elements of two organisations into one. In another of our sites, three public health teams formerly based in PCTs

merged into one public health team, based in one council, but providing services across three councils. As this change happened, the teams went through various reorganisations, shedding staff at each point. In another of our sites the majority of the PCT based public health team were retained in the transition, but many had changed job titles and roles. This study site had one PCT, which was part of a larger cluster of three PCTs. Staff from the PCT cluster then transferred to a single CCG when first authorised (2013) but has subsequently merged with a neighbouring CCG. The public health team in another site moved into the council a year before the official transition and there was a restructuring of public health, with the LA's existing substance misuse and teenage pregnancy teams joining the public health directorate.

Examples of smooth transition occurred where some existing organisational arrangements had been established. In one site there had been a health unit providing a bridge between public health, the LA and the PCT. The majority of public health staff transferred from the PCT into the LA but subsequently the size of the team was reduced.

Issues of staff anxiety, with some PCT public health staff choosing to leave rather than become council staff, were commonplace. There was much confusion over both where staff should be moved to (sometimes depending on the proportion of their time spent on service commissioning versus service provision), and where and how much money should be moved. The confusion around organising budgets in particular was in some cases extremely complex, and there were instances where this tested relationships between councils and the new CCGs. This was made more complicated in sites where there were multiple organisations coming together, and/or where multiple new organisations were created.

3.2 Defining roles and responsibilities

There were complaints about lack of clarity and guidance from government, for instance, with regards to responsibilities for commissioning services across a pathway. Some commissioning pathways in particular – for instance for obesity and for sexual health – were talked about as having become a lot more complex than before the reforms, with responsibilities split between the council, the CCGs, NHSE and PHE. The lack of surety about responsibilities sometimes led to delays in the commissioning of services, and sometimes led to tensions in the relationships between organisations. In one of our case study sites, the council went ahead and commissioned tier three obesity services before clarity was achieved at a national level (in March 2014) over who was responsible for commissioning what. In the national guidance, it was concluded that: *“Clinical Commissioning Groups (CCGs) should have primary commissioning responsibility for tier 3, clinician-led specialist multidisciplinary teams”*³. In this site, the council were then faced with trying to get a number of CCGs to take over the responsibility for purchasing the new service across the county.

The lack of clarity around roles and responsibilities was also related to continued flux and reorganisations of public health teams, as departments went through various processes of change,

³ See Joint report on commissioning obesity services - <https://www.england.nhs.uk/2014/03/comm-obesity-serv/>

many of which meant reducing staff numbers and/or changing staff roles. CCGs also had an important journey to make as they formed, became authorised, took on full responsibility for clinical commissioning in their area, and more recently (2015) started to co-commission primary care with NHSE (see McDermott et al 2015). CCGs are significantly pared down compared to PCTs, and as a result, have to buy in many services required for their successful operation. Some of these services are procured from new CSUs.

There was role confusion across the system including at regional and national levels but also between levels. One regional respondent commented:

“We now have a national tier which should be a great asset and indeed in many ways it’s a huge additional capacity but the problem is that it is trying to see itself as a national service with this kind of operational side which needs to interlock, you know, with a new set of dynamics really and then what we haven’t ever sorted out is the relationship between that national tier and the Department of Health and indeed other government departments which may be sort of softer measures.”

One DPH highlighted the need for more national clarity and guidance:

“... the hands-on support that we get through health protection and through some of the health improvement at the centre level I think is great and really helpful. I think that some of the information products are very good ... but when it comes down to thinking about guidance and so-on, I’m not sure that there’s any product that’s come out yet that I’ve looked at and thought yeah, that helps me to think about how we should do this.”

Respondents did identify improvements over the period of the research, but concerns were still being raised in 2015 about who was responsible for what. The situation was not helped by the continuing changes in roles and responsibilities as these continued to be transferred between organisations.

3.3 System development

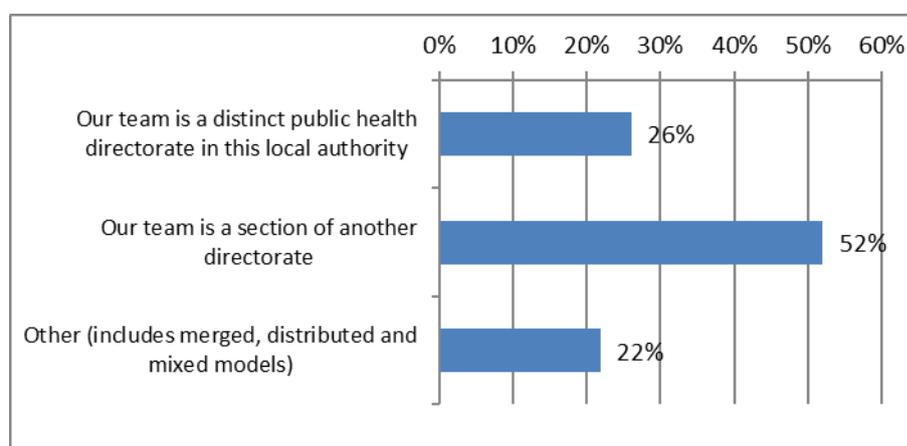
A key finding from the first phase of case study work relates to the long period of time it was taking the systems to ‘settle in’; we were frequently told “it’s early days” by research participants, even two years after some of the public health teams had moved into the councils. The concurrent and sometimes repeated re-organisations of councils as they simultaneously sought to adjust to severe cuts to their budgets, made the context more difficult for the in-coming public health staff. This is a story that has continued throughout the duration of our research. Public health teams adopted various organisational arrangements as they settled into their new local government structures and processes. In March 2012, the LGA/DH (2012a) noted that models for the emerging systems in LAs could be described within three broad categories. By September 2012, a fourth was added (LGA/DH 2012b):

1. A distinct public health directorate in the LA (often including additional LA functions).

2. A section of another directorate – generally the directorate with responsibility for adult social care or a chief executive/corporate directorate.
3. A ‘distributed’ or ‘integrated’ model in which public health responsibilities and staff work across directorates or functions but maintain identity and focus through being a ‘virtual team’, a ‘hub’ or a ‘core and extended’ team.
4. A merged model in which public health and another local LA directorate are combined (e.g. the merging of public health and adult social care into a directorate of adult social services and health).

The overall profile of public health team location and arrangements reported in our 2015 survey was very similar to our previous survey. In 2015, just over half were part of another directorate (52%, N=73) and just over a quarter were a distinct public health directorate (26%, N=73, Fig 1).

Figure 1: How is your public health team arranged in this local authority? (2015 DPH survey N=73)



There were also many sharing arrangements for the public health function across councils. Our interim report noted that of the 96 DsPH responding to our first national survey, nearly a third (32%) led public health teams providing services for between two and eleven authorities (Peckham et al 2015:10). Our 2015 survey found that a similar proportion of respondents (32%, N=74) reported that their public health team delivered a service that was shared, but for 5 authorities this was a new, if only a temporary arrangement for two of these. Sharing arrangements were usually between unitary authorities. The 2015 DPH survey asked if respondents thought that there would be new arrangements between authorities to share public health staff or responsibilities; 14% (N=73) expected such changes would happen. This demonstrates a significant degree of continuing organisational turbulence.

Given the variety in team arrangements, it is perhaps unsurprising that we also saw variation in line management accountabilities. 47% (N=73) respondents to the 2015 DPH survey said they were directly managed by the Chief Executive, compared to 42% (N=91) respondents in 2014. In 2015, the overall proportion of DsPH who were members of the authority’s most senior corporate

management team had not changed (53%, N=73 in 2015). The year on year comparisons for authorities that replied in both years again showed that overall proportions could remain steady yet mask a considerable amount of change in individual authorities. For example, of the 22 DsPH not on the most senior corporate management team in 2014, four (7% N=56) were in 2015 and of the 34 DsPH who were on the corporate team in 2014, only 23 (20% N=56) remained so in 2015. This was an issue of particular concern and is discussed later in this report (see Table 5 and Sections 4.1.2 and 4.2.2).

Table 5: Are you a standing member of your local authority’s most senior corporate management team? (Sub-set of LAs replying in both 2014 and 2015 DPH national surveys N=56)

		2015		Total
		Yes	No	
2014	Yes	23 (41%)	11 (20%)	34 (61%)
	No	4 (7%)	18 (32%)	22 (39%)
Total		27 (48%)	29 (52%)	56 (100%)

In some respects, it has taken time well beyond the transition year to organise public health structural capacity and roles and responsibilities in relation to public health practice. The issue of leadership and governance at national level has been problematic, with PHE’s role here taking time to develop. Their roles and relationships vis-a-vis the DH and NHSE have been complex and difficult at times (see section 5). And at local level too it has not been easy, with public health professionals having to forge their leadership role within councils, alongside elected members and other senior officers with much larger directorates (see section 4).

3.4 National and regional arrangements

At regional level, upheaval continued with PHE regions being reformed following the PHE strategic review that occurred at the end of 2014. The review was to set out a plan of how PHE would manage an impending cut (of approximately 22%) to their 2015/16 operational budget. A key change included reducing the number of PHE centres from 15 to 9 (8 across the country and one in London). The regional directors’ roles changed. In the NHS, regional groupings are emerging – for example, in London CCGs are forming themselves into super commissioning units called Strategic Planning Groups. Individuals and teams in PHE and NHSE have had to work hard on developing good relationships sometimes in the face of complaints about lack of parity in pay, training and support, and where distinctions between the two organisations are not always clear, with staff employed by the two different bodies often working in one team, sometimes “feeling quite duplicative” and with “the potential for tripping each other up” (senior manager NHSE).

While PHE was not a particular focus of our research, its development has had implications for the overall development of the new public health system in England and we undertook some additional

interviews to explore the LA and PHE relationship in particular. PHE, at the head of the national public health system, is a complex organisation. PHE's structure includes: a national office, including national centres of expertise and four geographical hubs that oversee its locally facing services; units that deliver its locally facing services and act in support of LAs, other organisations and the public in their area; and a distributed network for some functions, including information and intelligence, to allow them to be located alongside the NHS and academic partners. PHE was established to be the national system leader but at a LA level this was not particularly well recognised:

“The honest truth about the national level is I think that it is just way too concentrated on the national element rather than looking out towards the regions. It does feel distant. So actually in a way it almost feels like the local centre is close to us and wants to operate with us but then there's this sort of gulf between that and the national set up and I have to say I don't really think it's the fault of the national end; I think a lot of it's about the sort of disempowerment that's built into the nature of Public Health England which is a much bigger problem than I think a lot of people had understood at the outset.” (DPH)

On commissioning national programmes, PHE needed to work closely with NHSE at national and regional levels. Even into 2015 we identified some concerns about this, partly as a result of differing cultures and partly because of a focus on some key areas dominating work programmes – for example the transfer of 0-5 year-old public health commissioning to local authorities. While NHSE acted as commissioner for national programmes it was taking time for the relationship to develop as described by this NHSE Manager:

“... I suppose we've been expecting a bit more dynamic leadership from PHE in terms of some of these health issues and I'm not sure we get the best out of what they have got in a way that we can use it well. I think that's just... it just takes time and getting to know what's there and then thinking about how we use it because there's hundreds of tools that they've got but I think there's just so many and we're a bit not overwhelmed but we really haven't got our... we haven't got a really good systematic and sort of consistent approach to how we use those tools and make the best of what they're doing so I think we've got a bit of a... a bit more work to do to get better at using our PHE colleagues...”

Some senior managers in NHSE and PHE, however, reported good working relationships, with one senior NHSE manager reporting that “...I see very good working relationships between PHE and NHSE right from senior management team”.

3.5 Summary

Our research suggests that the development of the new public health system in England is still in progress with the internal organisation of public health in LAs, the NHS and PHE very much in a continuing state of flux. In LAs in particular, the additional organisational upheaval that has been a feature of local government has had a significant impact on the way the organisation of the new public health function is developing. This is discussed in more detail in section 4 of this report. While no specific guidelines were provided about how public health should be organised in local

authorities, it was clear from our research that irrespective of whether partnership arrangements were in place before 2013, the transfer has been both organisationally and culturally complex. There does not appear to be a national picture, with substantial variation between areas.

Agencies are still developing their roles, often coping with complex internal changes as well as needing to develop new relationships with other agencies (discussed in section 5). The fragmentation of aspects of public health –e.g. commissioning – has created particular problems. Lack of clarity about roles and responsibilities and difficulties in aligning local and national priorities have also resulted in often difficult discussions between organisations. There was a degree of uncertainty about what organisations expected from other agencies. For example, there was an expectation that PHE would provide more support regarding health promotion and national campaigns, and lack of clarity about tier three commissioning has led to variation in how these services are funded and provided. On the other hand, LAs generally appreciated the information support from PHE and were also building links with local PHE staff.

4 Public Health in Local Authorities

The government expected that, by placing public health staff and funding within LAs, stronger relationships would develop between public health professionals and LA personnel across all departments, so that public health might become more 'embedded' within all LA work. The DPH, as the lead officer in the LA for health, would champion health across the whole of the authority's business.

This section reports on findings from our research related to that policy expectation of embedding public health into LAs, and the subsequent expectation that, as a result of this embeddedness, public health activity will change to include a greater emphasis on the wider determinants of health, and to combine traditional 'public health' activities with other activity locally to maximise benefits. We begin this section by considering how public health staff are organised within LAs, and what opportunities are being brought to both public health staff and to the LAs. We then explore the organisational capacity within LAs in relation to carrying out the public health function. Finally, we consider the extent to which public health activities are different now, within this new environment.

4.1. Organisational arrangements and key people in local authorities

Public health teams moved into long-existing organisational structures with strong organisational cultures, and different processes, mechanisms and ways of working to those they were used to. Even where public health teams previously had joint appointments with local councils, there was still something of a 'culture shock' for individuals working in their new environment (Peckham et al 2015 p22). It has taken a long time for public health staff to become familiar and at ease with the different ways of working required within LAs.

One key difference is that public health staff are now officers reporting directly to elected members, and it is those elected members who are the key decision makers. LAs have mechanisms built in to their decision making processes to ensure stronger democratic accountability – decision making processes usually involve close working with the lead elected member, a number of committees, sub-committees, and cross-departmental groups, and various consultations both with councillors and the public. To a public health staff member, this process can feel lengthy, bureaucratic, laborious and sometimes frustrating (Peckham et al 2015). However, there were signs in our case study work, that public health staff both saw the value of these processes and the scrutiny they bring, and were getting used to working with them, and to working them to their advantage. For example in one of our sites a programme manager for childhood obesity commented that:

“it's actually a very robust process and explains well how we are going to spend public funds, because you are justifying your business needs and getting feedback to see if it's the right thing to invest in, you've got chances for peer review, and you can get an understanding from your colleagues about where they think would be a better area to focus on, you have to get legal clearance, financial clearance, so it's all formally done, and then it goes to the decision makers. So by the time it gets to the cabinet it has been through all of that”.

And in another site a public health manager talked about the support they got from elected members:

“I think they see public health as being one of the...shining lights really in the... council...in comparison to other services that are obviously experiencing significant cuts...we’ve got to make £150 million worth of cuts over the next few years...700 job losses, so public health is a really good news story. We’ve got the political support because actually the elected members can see that...if we do well...there’re lots of opportunities for press releases and media coverage, et cetera”.

Several of our sites benefited from appointing long-standing LA personnel to their public health team. In site A, this included a business/strategy manager who helped the public health team to navigate the council structures and processes.

4.1.1 Relationships with elected members

Overall, our findings suggested that relationships between public health officers and elected members were good and valued by both parties. In site A, for instance, the elected member with the health portfolio was interested in the work of the public health team and fairly ‘hands-on’ (weekly or fortnightly meetings with key public health staff), but at the same time respected the authority and expertise of the public health professionals. Elected members were playing a role in aiding cross-directorate working, and they had an eye towards monitoring outcomes. In most of our case study sites, the elected members were positive about and interested in public health, and had often played an important role in helping the public health team to become embedded within the council. The cabinet member with the health portfolio in site B explained, in June 2014, that she

“was very keen and asked them [public health] to put together the programme for how we engaged all the other departments within the council and... which they’ve done, and that will be a programme that starts very soon”.

In site A, a cross-council public health board, comprising councillors, key members from the public health team, and representatives (officers) from each of the directorates, was established to:

“Bring together colleagues across [the council]⁴ that deliver public health outcomes and ensure [the council] maximises its opportunity to improve the wider determinants of health; drive a new approach to public health - bringing innovative and new approaches to tackle health inequalities; collectively agree resource and approach to improve performance where [the area] is an outlier; organise sessions with partners to drive a whole system approach to improving the public health wherever possible” (from document presented to Public Health Board, July 2014).

⁴ Text has been altered only to preserve site anonymity.

The DPH in site A talked of ready access to the leader of the council, and public health staff saw their elected member as open and approachable:

“I see him ... to respond to any queries that he may have, to brief him, sometimes I seek to go and see him in terms of proactive management because I’m that kind of a person; if I know that I have something coming up and I feel that he should be aware of it, so I just go ... It’s about involving him and he’s a very approachable person” (PH consultant, site A).

In general, public health staff felt their work was valued by the council and elected members, and councillors also talked about their public health teams in a positive way. For instance, in the 2015 survey, 52% of DsPH (N=73) and 61% of elected members (N=38) with the health portfolio felt that the teams were ‘definitely’ valued, citing a variety of enablers for this such as strong leadership and quality of their work. This county councillor in site D said:

“I’m impressed with public health ... I’ve got to say I think they’re a good group and they’re working very hard with limited funds, and so with public health more than anybody they’ve got into the joined up thinking. So public health ... are doing really well as far as I’m concerned and they are setting an example so some other areas could follow the same”.

Whilst most elected members across our sites were positive about their new public health duties and staff, there was just one site where one councillor took a negative view, based on their perception that public health staff were insufficiently pro-active. This negative view was also heard from a minority of non-public health officers interviewed in our case study sites.

4.1.2 Relationships with other council officers

The relationships between public health staff and other council officers are a crucial aspect of achieving ‘embeddedness’ across the council. These relationships have obviously taken time to develop and have not been helped by the turbulence within the councils, with many departments restructuring on a frequent basis, and with staff leaving or moving to different positions (see section 4.2).

However, our surveys continued to demonstrate the view of both DsPH and elected members that public health staff had ‘definitely’ built good relationships within the authority (77% of the 73 DsPH, and 74% of the 38 elected members replying). As in 2014, the views expressed in the 2015 survey were fairly equivocal - that public health staff were ‘definitely’ valued, and that staff in other departments asked for and trusted public health advice. Although there had been an increase in the proportion of DsPH who thought that staff in other departments knew what public health staff could offer, this still remained at only 26% (N=73) saying ‘definitely’ (up from 14%, N=85 in 2014). In authorities where the DPH had responded in both years to the survey, progress could be seen in several areas, and confirmed the DPH view that there had been an increase in awareness of what the public health team could offer.

When correlating DsPH survey responses on the integration of the public health team within the LA, many statistically significant associations were found with other variables. Building a good

relationship was seen as the best measure of integration from survey data and it was found to be associated with the team being valued, being asked for advice, and their advice being trusted. It was also associated with active use of public health team services such as provision of data, needs assessment and inequalities analyses. The only significant association to be found among the views of elected members regarding integration was between having built a good relationship and public health staff being valued.

Within the surveys, DsPH and elected members were asked to provide three enablers and three barriers to successful integration of public health within their authority. From the many free text responses, a number of common themes were identified – see Table 6.

Table 6: Views on enablers and barriers to successful integration of public health: key themes drawn from free comments within the 2015 surveys

Views on successful integration of public health	DPH perspective	Elected member perspective
Enablers	<p>Good working relationships and team working across the organisation.</p> <p>Delivery of high quality work.</p> <p>Strong support and leadership from the chief executive and others.</p> <p>Merging work streams and priorities.</p> <p>Raised profile of the public health offer across the LA.</p> <p>Other enablers: availability of ring-fenced public health grant, closely located team, good team structure, access to LA levers, skills and links.</p>	<p>High quality public health staff and competent DPH.</p> <p>Good working relationships across departments.</p> <p>Joined up and integrated working.</p> <p>Leadership and wider political support.</p> <p>Other enablers: good structure and location of the public health team, public health funding.</p>
Barriers	<p>Financial pressure from LA budget cuts and austerity in general.</p> <p>Pressure to use the ring fenced grant to cover cuts in other areas.</p> <p>Negative staff behaviours.</p> <p>Mismatches in ways of working.</p> <p>Lack of understanding of what public health does.</p> <p>Other problems: issues with roles and responsibilities, lack of staff / capacity, differences in culture and organisation.</p>	<p>Differences in ways of working.</p> <p>Financial cuts.</p> <p>Lack of understanding of the public health function.</p> <p>Other barriers: professional tensions and cultural differences.</p>

A number of the enablers and barriers summarised in Table 6 relate to the position of public health staff relative to others within the council. As stated in our 2nd interim report (Peckham et al 2015: 13-15), and in section 3 above, reporting lines from public health to the chief executive were seen by public health staff as important. Also important was having a public health presence on key fora/groups (both management and strategic). We also highlighted in our previous report the

relationship between organisational arrangements and the degree of influence afforded to or felt by public health professionals, especially the DPH (ibid p25). Reporting lines and related influence can be complicated within the new arrangements. For example, a non-public health manager in one of our sites observed that the DPH technically reports to the Chief Executive. However, the DPH was not a strategic director and the DPH team reports to the Director of Adult Social Care. It was noted that the DPH attended the social care management meetings, but not the strategy group meetings. Yet, the manager commented that: *“The trick is to be a member of the strategy group so you get on all the strategic discussions every week”*. This interviewee felt that a new service provided by public health was not effective because many of the staff running the new service were under the purview of the Director of Adult Social Care:

“But basically ... [the DPH] has to feed in through the Director of Adult Social Care. That’s partly where the [new service]...model’s not working that great, because part of the stitch up of that was, that had been provided by his [Director of Adult Social Care] staff...and it’s hard to performance manage your boss’s staff”

There were many factors that influence the ease with which, and the extent to which public health staff became embedded within their new organisations (see also section 3, which describes organisational arrangements of public health teams). However, it is clear that since the reforms, public health officers found it easier as time went on, and were finding more opportunities to work with other departments in the same council. They were also finding that they were more able to influence priorities within the council, and to influence the work of the council as a whole.

Our surveys asked about the influence DsPH felt they had with respect to improving the local population’s health. Nearly two thirds of DsPH (65%, N=71) said they were ‘quite often’ able, and between 2014 and 2015, there was a modest shift towards more DsPH saying they ‘always’ felt able to influence the priorities of their authority (21% in 2015, compared to 15%, N=86 in 2014) and away from saying this was ‘not often’ the case (13% compared to 17%). However, in 2-tier authorities, no DPH felt they were ‘always’ able to influence their authority’s priorities in regard to improving health.

In both years’ surveys there were some statistically significant associations between the perceived ability of DsPH to influence priorities in their LA and other key variables. In 2015, the strongest associations were found between feeling influential and the DPH having gained additional responsibilities (a new finding), the public health staff being valued, others knowing what the public health team offered, the team being asked for advice and it being trusted.⁵ When a DPH was a member of the most senior corporate management team, this was associated with being ‘quite often’ able to influence council priorities.⁶ No clear differences were seen for different types of LA, although in 2015 there was some indication that DsPH in inner London and South East authorities

⁵ all chi-squares between 7.682 and 12.702, df = 2, p values between 0.002 and 0.021

⁶ chi-square = 6.282, df = 2, p=0.043

felt they had less influence, and those in non-London unitary authorities and the North West region had most.

In site A, a DPH pointed to the opportunity for public health, within its new home, to help break down pre-existing barriers between directorates. More than two years after transferring into the LA, the interviewee said:

“the organisation’s quite siloed in the sense that you’ve got [these different directorates]. We’re breaking down some of those barriers by starting to facilitate working between the directorates now on things that actually you think oh did it take public health to get everybody together?”

This DPH stated that he now works *“far more closely with other directorates”*, and credits the location of another corporate director in the next-door office as being important in that. The benefits of ‘corridor conversations’ with members and officers in other departments were mentioned by other interviewees too. The DPH in site A saw the positive influence public health was having on the LA:

“even when we’re not involved in stuff I hear now other colleagues saying, ‘well, we’re taking a public health approach to this, so we’re doing the analysis of all the data first and try to understand where we are before we decide where we’re going to get to”.

“So quite often, you know, no matter where our leader goes, he hears all the other directorates talking about public health and we’re doing this with public health or we’re doing that with public health”.

In the context of budget cuts, the bringing in of public health presented opportunities to other directorates (such as the pooling of financial and human resources), as this head of service (non-public health) in Site D explained:

“We’ve been able to do stuff in quite glorious isolation before, and we do not have the resource to do that anymore. And if we want to achieve things, some of them which are a statutory requirement, we’ve got to think about how to do it differently”.

In some cases, these opportunities could feel like a threat to public health officers, who were now in the position of protecting and defending their public health budget. A non-public health manager in site C commented that:

“The biggest problem was public health came across with a big ring-fenced budget at the time that austerity kicked in, so basically, all the Directors of Public Health have had to do, is to defend their budget, rather than integrate. So the timing was awful”.

However, in several of our sites, the public health teams seemed reconciled with the fact that the public health budget would now be used to fund other services – in many cases, services that would have been cut had public health funding not been available (see also section 4.2.2 – financial capacity). In sites A and B, public health investments into other parts of the council (such as children’s centres, or environmental health) have helped to build relationships, and have helped to embed public health outcomes and ways of working in other departments (for instance, by ensuring evidence is collected in order to be able to assess outcomes over time). In addition, a transport manager in site D noted how public health had co-funded various initiatives with them, and discussions were underway on pooled budgets in certain areas. In site C, a public health lead commented that:

“We’ve gone through a process here by which over two and a half million pounds of the public health budget is now going into broad council services that are delivering on public health outcomes, and that’s been done very appreciatively here as a process”.

In the same site, a (non-public health) HWB member observed:

“...public health put £100,000 into sort of, the grants pool and is, sort of, you know, topping up the voluntary sector pot effectively and there’s been some quite interesting work that’s come out of that and, I think, they’ve been quite keen to get involved in that side of the council so it’s, sort of, worked both ways... But also it’s made people think a bit more whereas, oh, well, we’d always just fund this. A council service, we’d just fund it, and now we say, oh, shouldn’t public health be funding it”.

Whilst there was a generally optimistic sense about the extent of embeddedness across the councils, it was often voiced in tentative terms, using words like ‘beginning to’, or ‘plans for’. However, we came across some good examples of joint working at project level. One public health officer (site A) demonstrated having worked with other officers right across the council on developing an active travel strategy and programme proposals to address physical inactivity. In site B, interviewees discussed joint working on a large work programme on childhood obesity, which enabled public health to work closely across the LA, and promoted a ‘whole council approach’ to obesity prevention.

In our interviews with members of other directorates, there was often a desire expressed to work collaboratively with public health, and most mentioned that they would like to engage more with them but were hampered due to the lack of public health resources (see section 4.2). A transport manager in site C commented on how the lack of human and financial resources was an issue for joint working with public health with the result that *“...you will do an hour here and an hour there. Yes, it’s not the ideal way of doing it, but it will hopefully bring benefits eventually”*. A planning manager in one site remarked:

“...I mean, first and foremost the most recent change with public health has been budgetary pressures which have seen reduction in the number of people working in the public health

side, because before that, and I think it will go on but with less support or urgency, a project has begun to sort of say how do we integrate public health and planning, how do we integrate public health into planning or health into planning in a more effective way? Because there has been some discussion for a while about what planning can do in terms of public health.”

In two of our sites, planning officers mentioned that they have had to seek engagement from public health and go ‘knocking on their door’ rather than the other way around. In both sites, there was pressure from councillors (who objected to the increasing number of fast-food shops) to address both the proliferation and health impact of hot food takeaways.

Whilst some sites demonstrated areas of joint work with planning, such as in site C where there was joint work on hot food take-away premises, in other sites, work with planning departments seemed to be particularly slow. Interview data indicated that this might be due to lack of understanding about *how* planners can make a difference to population health, or it might be due to apparently conflicting agendas. Either way, it appeared from our case study work to be difficult for public health officers to get a foot-hold in this area. A public health specialist in one of our two-tier council sites described her experience of trying to engage with planners within a group of district council planning officers. Despite presenting positive examples of joint work carried out in the neighbouring (unitary) authority, the group were reluctant to engage:

“they were really coming from quite different... I think there’s a genuine concern from planners in [this county] about, you know, the life of town centres, you know, in terms of making sure they’re vibrant and so-on and I think they... I think they find that quite difficult...[The subject] got a very good airing, but I think that the feeling I got from that was kind of on balance, they might look to see where [the neighbouring authority] goes with it, they might look to see where other authorities go with this, but at the moment, you know, they’re not as one, they’re not really going to take that agenda on, I don’t think, at the moment” (PH specialist).

A planning respondent in site E said that whilst they *wanted* to include health in planning, current policy favoured commercial and financial aspects of getting developments built (housing developments) such that *“it’s not because it doesn’t care about health, it’s just because it balances lots of other things”*. Several interviewees talked about the different pressures that planning officers were faced with, which make the integration of health more challenging, and one (non-public health) interviewee in site B said that public health and planning *“have different ways of talking about things”*.

There were obviously more difficulties in working with relevant departments (such as planning, leisure, housing, environmental health) in two-tier authorities, since these departments are found in different organisations – multiple district councils, each with their own organisational structures, processes, histories and cultures. The challenges of working across multiple district councils were made clear in our two county sites. In county sites, the public health teams did not benefit from

being in the same location. In addition, there was a key question of public health staff capacity, since a small pool of consultants and specialists might be spread across up to 12 district councils. In site D, whilst there were examples of good links between public health and planning in one district (public health staff conducted a rapid health assessment of a new housing development and suggested improvements in a number of areas), in another district, there were seen to be potential barriers to joint working, as this planning manager noted:

“...we’re not all in the same building and we each have our different politics and we each have our different cultures of the organisations. All of those things just add to the difficulty of it in my mind and...I’m just...being brutally honest...if I was to go to my boss and say, you know what, we want to do this, we want to hook up with the sustainable travel of the county and with public health to promote some cycling routes, the first question I’ll get is, well, that’s a lot of effort, where’s your business plan? What are you going to get out of it?”

4.2. Organisational capacity

The reforms were expected to bring about better public health outcomes, without the investment of significant extra resources (and indeed, despite the contraction of financial resources). Improved outcomes were presumably expected to arise from existing capacity (such as tools, skills, staff and infrastructure) being used in new ways, or perhaps being more effectively used within new structures, systems and roles.

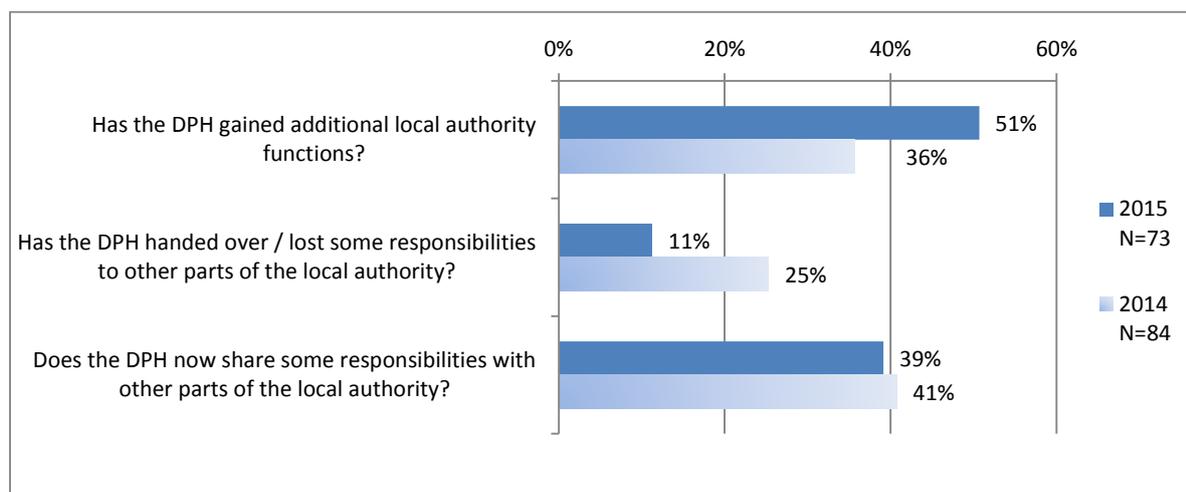
Some elements of capacity (eg. organisational structures, systems and processes) are difficult to assess and quantify, and others still are even more ‘invisible’ (eg. organisational ‘attitude’, empowerment and identity). But the inter-relationships between different elements of capacity are important. For instance, if a public health team has money, IT equipment, software, and access to public health data, it has a certain amount of capacity. But that capacity is of little use without personnel capacity in terms of staff sufficiently knowledgeable, skilled and confident to make effective use of the tools available. Furthermore, a public health team would need to include a varied range of skills and experiences sufficient to effectively work across all three domains of public health (health improvement, health protection and improving services). Assuming the team is optimal in terms of personnel capacity and its ‘fit’ with both the type of work and the workload, there needs to be clear processes whereby the staff are supported, supervised and motivated, for the organisation to make the most of the team’s performance and personnel capacities. In order to make best use of the staff team, the facilities and the support services, appropriate structures, systems and processes are required. These sections explore some of these aspects of capacity.

4.2.1 Personnel capacity

It seems as though public health staff are increasingly being ‘stretched’ across a greater geographical area and/or range of organisations. Public health staff are often shared across councils (see section 3 – sharing arrangements were reported by a third of our respondents). In addition, in some councils, public health staff are also increasingly being ‘stretched’ across other service areas. When asked about changes in responsibilities, more DsPH in 2015 said they had gained additional

responsibilities (51%, (N=73) compared to 36% (N=84) in 2014), and fewer had handed over responsibilities to other parts of the authority (11%, (N=71) in 2015 compared to 25% (N=79) in 2014). The free text replies gave more details, showing that DsPH were taking on responsibility for areas like leisure, culture, libraries, environmental health, as well as adult social care and early years. (See Fig 2). Whilst the 2014 DPH survey found that in most cases public health teams either remained the same or were made smaller (see section 3.2 of Peckham et al 2015), replies to the 2015 survey suggested that the situation had not altered during the intervening 12 months.

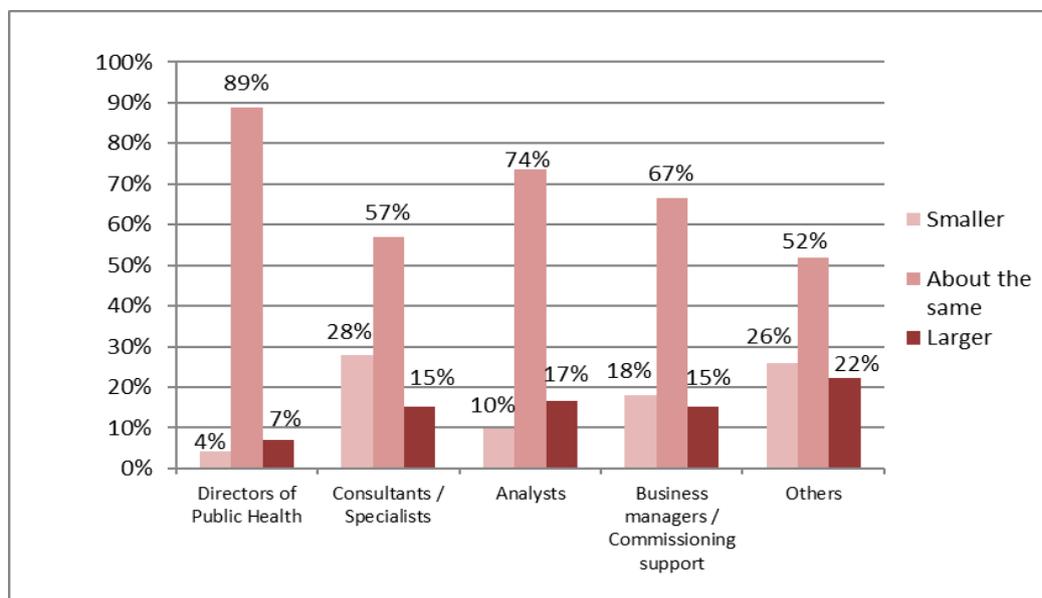
Figure 2: Have there been changes in the last 12 months in DPH responsibilities? (DPH surveys)



Several interviewees in our case study sites talked about having to address skill gaps in their team following the transition. Sometimes this was to be able to carry out a previously taken-for-granted function that was provided in-house within a PCT (such as finance or procurement). At other times this was to be able to address the new requirements for scrutiny and accountability within the council (such as business and strategy planning). Some public health teams (like that in site A) were adjusting to a new role solely as commissioners, rather than commissioner/providers, and consequently employed more commissioning experts who did not necessarily have public health training and expertise. Simultaneously, the pool of public health consultants and specialists in some public health teams (e.g. in sites A, B and E) has reduced. Our national surveys confirmed that these two professional groups had been most affected by staff reductions with 28% (N=72) of authorities reporting smaller numbers and only 15% reporting there had been increases in public health consultants and specialists (See Fig 3).

In addition, public health teams in our case study sites, like all those across the country, have lost public health expertise to PHE and NHSE, which has attracted a significant number of public health staff. A non-public health manager in site C commented that a lot of public health professionals were “lost” in the transition to LAs, and most of the “progressive” public health practitioners did not enjoy working for local government and have gone back to the NHS and other organisations – partly for better terms and conditions. Speaking about site C, the manager noted that: “...I think, [it] has two or three of the originals that came across. That’s been a problem”.

Figure 3: Changes in the last 12 months to size and composition of the public health team (2015 DPH survey N=72)



In site B, one consultant talked about the impact on capacity of having had to restructure their workforce prior to moving across to the LA (a restructure driven by cost savings). In this particular restructure, everyone below band 7 was made redundant, so that the public health team contained only a ‘qualified’ public health workforce:

“So we lost a lot of prolific workforce because [this team] had a long tradition in bringing people in, giving them the opportunity to get a lot of experience and either start their Masters degree or certainly get enough experience to apply for public health training scheme so we always had a tradition in actually being sort of a little nursery for people for the training scheme and we lost that” (PH consultant site B).

An interviewee in site A voiced concern about the maintenance of professional standards outside of the NHS system. Similarly, in site C, a public health officer talked about her realisation that in LAs, ‘professionalism’ isn’t such a highly emphasised quality as it is within the NHS:

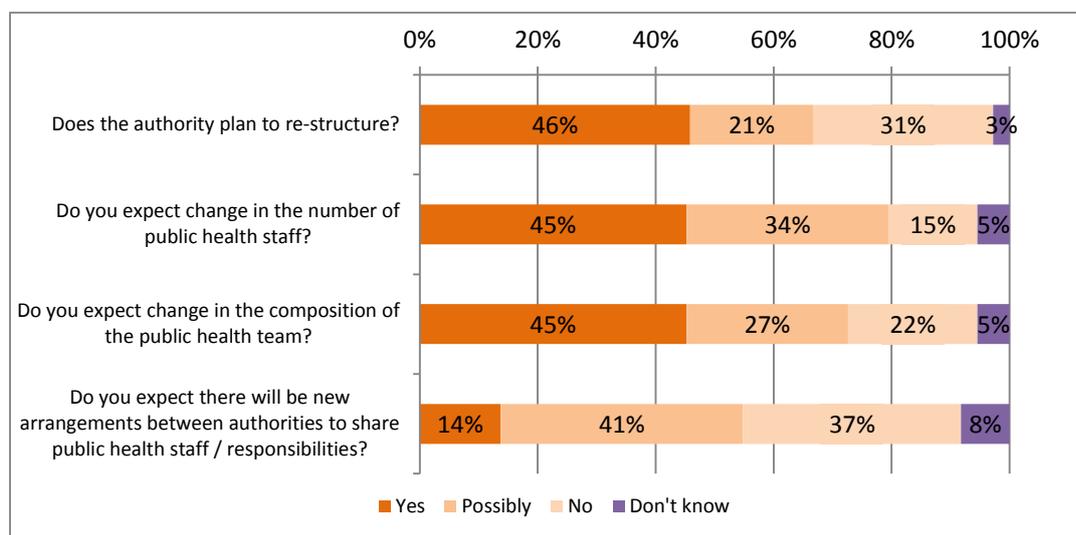
“Like we had a senior manager’s conference, and it was brilliant the way it was done ... they had a quiz - what’s your top thing that you would think that people want to see from [this] Council? And on my table I said professionalism is top of the list. And when we went around the table, professionalism on our list, for our table, came about fifth. It was the only word I said: professionalism ... I don’t think anything is higher than professionalism, from the public’s perception. It’s public money, so you’re paying for professional help, support, advice, standards, governance. I thought, I’m on a different planet to these people. Lovely people, don’t get me wrong, want the best thing, but the first thing that came to my mind, is very different to the first thing that came to their mind”.

Another consultant in site C felt that the dispersed distribution of the public health staff across the organisation was also a threat to maintaining “that professional culture and skills”. A policy officer in site A talked about a possible clash between professional values and organisational values. He concluded “I think that’s been a genuine tension for some of the people who’ve come over from public health; is their ultimate responsibility to their profession or is it to their organisation?”

As already mentioned, there is continuing flux and turbulence present in the system, with significant changes to the structure of public health departments and loss/upheaval of staff. This situation appears to be ongoing for many public health departments who were experiencing continued changes to staff, team structures and services. In the surveys, we found that only 79% of authorities (N=57) had the stability of having a DPH in both years. However, for the remainder there were other arrangements or changes in leadership, including switching between established and acting DsPH, and some newly appointed DsPH. This meant that there was a mix of stability and turnover among those in the role of DPH.

New questions in the 2015 survey were asked about plans for further changes affecting the public health team (Fig 4). Nearly a half (46%, N=72) of the DPH respondents said their authority planned to re-structure and that they expected (further) changes to the size and composition of the public health team (45%, N=73); quite a high proportion thought all these were possibly going to happen (between 15 and 25 out of 73; 21-34%).

Figure 4: Are there plans affecting public health teams in the next 12 months? (2015 DPH survey N=73)



Further analysis of the data suggested that DsPH views were not affected by the local arrangements or circumstances of their authority. However, there were (non-significant) indications that re-structuring was more likely in London Boroughs (83% (N=12) said ‘yes’, compared to 46% (N=72) for all LAs), and that there was less organisational change in two-tier authorities compared to unitary authorities (two-tier authorities were less likely to think that new sharing arrangements for public

health responsibilities or staff would be introduced in the next 12 months with none of the 16 two-tier respondents saying 'no', compared to 37% for all 73 LAs).

The case study work as a whole also highlighted the ongoing nature of reorganisations and redesigns, and research participants in all sites pointed to how unsettling this was. Interviewees in two sites (B and E) described continued feelings of flux within their organisational arrangements following departmental restructures, whilst interviewees in site A suggested that vacant public health staff posts and the loss of key staff was a continuing issue, although the team had grown. A non-public health manager in site C noted of the public health team that: *"...there's been a lot of people left...But I think things are obviously settling down, some people have moved on, some roles have changed within the team and I think, hopefully, it'll start to settle down"*. In one site in particular, respondents found ongoing re-organisation of the public health department and a planned service re-design particularly unsettling. Interviewees suggested that this meant uncertainty around future work arrangements and that the corresponding staff changes/reductions would ultimately impact on their capacity to deliver services. One interviewee felt that public health staff were at *"breaking point"*, struggling to cope with the dual challenge of lack of staff and finances to do the work needed. This was expressed as a dilemma of too much work and not enough capacity (resource) to do it.

The shortage of public health resources/capacity was also noted by other (non-public health) council staff. A non-public health manager in site C had the impression that public health is *"...spread quite thin"* and trying to do a lot but with insufficient resources. Coupled with this, the continual churn in public health staff (changing roles and staff leavers) is also unsettling for those actors in the council who endeavour to work with public health. For example, in one site a councillor described her frustration in not being able to access what she needed from public health as they were so resource limited. She explained that she found it difficult to work with public health because they cannot commit to anything, making it difficult to do forward planning (in this case on obesity prevention): *"you don't know what resource is going to be supporting that Food Board"*.

Similarly, in site C it was noted that capacity issues (lack of human and financial resources) were a factor in attempting joint working:

"I think one of the problems, one of the difficulties there has been is that because public health is a very big area and people are very heavily committed just doing what they're doing to hit it, and transport is a very big area, that these things don't develop just like that. There aren't people sitting down saying, oh well, you know, we can just do this, and we've got the time just to do this" (Non-public health officer).

However, our findings suggested that non-public health directorates were benefiting from the opportunity to utilise public health skills/tools across the council. Our surveys showed that results were little changed between 2014 and 2015 regarding the support that the public health team offered and how actively it was used across councils. For example, in 2015, 84% of DsPH (N=74) said that population and health data and needs assessment analysis were 'actively' used, and 60-65%

said that other types of support (monitoring data, inequalities analyses and support for commissioning) were 'actively' used.

4.2.2 Financial capacity

Throughout the time of the research, there have been further significant cuts in LA funding. Soon after public health moved into LAs, some councils were already using part of the public health budget to pay for services that were not previously within its scope – in some councils, this was talked about positively as investment (as described previously); in other councils, this was more negatively described as budget raiding (a discourse that was more common in the specialist press than in our case study interviews - see for example Iacobucci 2014, Iacobucci et al 2015).

In our first phase of interviews, interviewees referred to different uses of resources and the complex discussions about how public health resources were being both viewed within LAs and allocated. For example in one site a programme lead commented:

"...you've had a lot of scrutiny of public health budget, what can we get out of it from other directors and other team area[s], and you get all the usual push and shove that goes on around budget time, so a request perhaps from transport saying are public health going to pay for the gritting is one of the myths that everybody quotes but yes it does go on, and then there are a whole range of other topics where people are finding the boundaries and trying to work out what is health, what's the purpose, and I think that's been very difficult for everybody concerned".

And in another site, the DPH referred to obvious tensions in budget use:

"... I think the councillors will echo that, so we have been having very, very, very good support from our own councillors, both ways, so we have not been subject to a raid on our budget or whatever the..."

Interviewer: Not even at the start? Not even an attempted raid?

Interviewee: Attempts have been there."

In the case of sites A and B, a significant investment into other departments was able to be made because the public health teams underspent in the first year. This underspend was a direct consequence of the reforms, in that there were delays in budgets being finalised, contracts being moved across and staff vacancies. Later in the research period, in June 2015, a national cut to the public health allocation was announced (£200 million reduction (Williams, 2015)). Further, we saw evidence that the wider cuts to LA funding were also beginning to 'bite' and impact significantly on the capacity of public health to deliver non-mandatory services. For example, at the time of the interviews, there was discussion of weight management programmes being curtailed in site C and had been discontinued in site E, where they also drastically reduced the stop smoking service (discussed further in Section 6). Some interviewees expressed concern about the vulnerability of the

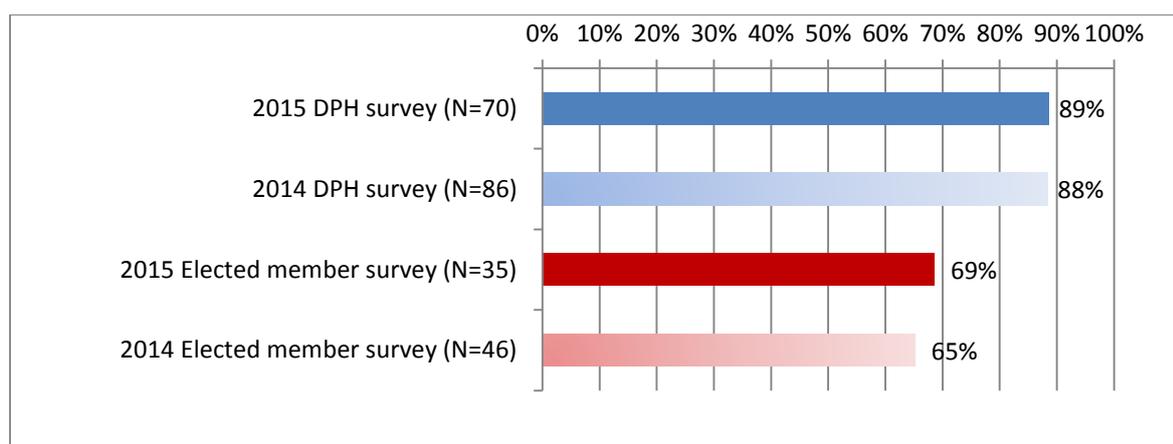
public health budget once the ring-fence was removed⁷, when the council would not have to specify what the budget was being used for:

“I think, it’s going to be harder and harder for local authorities like...[us] to not raid the public health funds or, you know, via the public health funds...if there’s no money to, ...take kids into care who need to be taken into care...but, I think, that’s where we are, at the moment, but when you’re struggling to carry out the basic statutory services then you’re going to look elsewhere for that money”. (HWB member)

However, this situation was very different for different authorities. Two of our sites either had an increase in public health investment or were not facing such harsh financial cuts (see section 6).

The surveys suggested that the situation of public health funds across councils was fairly ‘fluid’. About a quarter of DsPH (26%, N=70) responded in the 2015 survey that *additional* funds had been made available for the public health team’s work (this compared to 19%, N=85 in 2014). And 89% of DsPH (N=70, and 69% of elected members, N=35, Fig 5) said that the ring-fenced public health budget had been used to *invest* in other LA departments (a similar response to that in 2014). The free text replies showed that some DsPH had gained additional responsibilities in areas such as leisure, culture, libraries, environmental health, as well as adult social care and early years which might account for some of the additional funding. Comments about the public health budget showed that it had been used to invest in a very wide range of the council’s activities, including sport and leisure, children’s services, housing, employment, resilience, road safety, and that some investments were to prevent services being cut.

Figure 5: In the last 12 months, has the ring-fenced public health budget been used to invest in other local authority departments? (2015 and 2014 DPH and elected member national surveys)

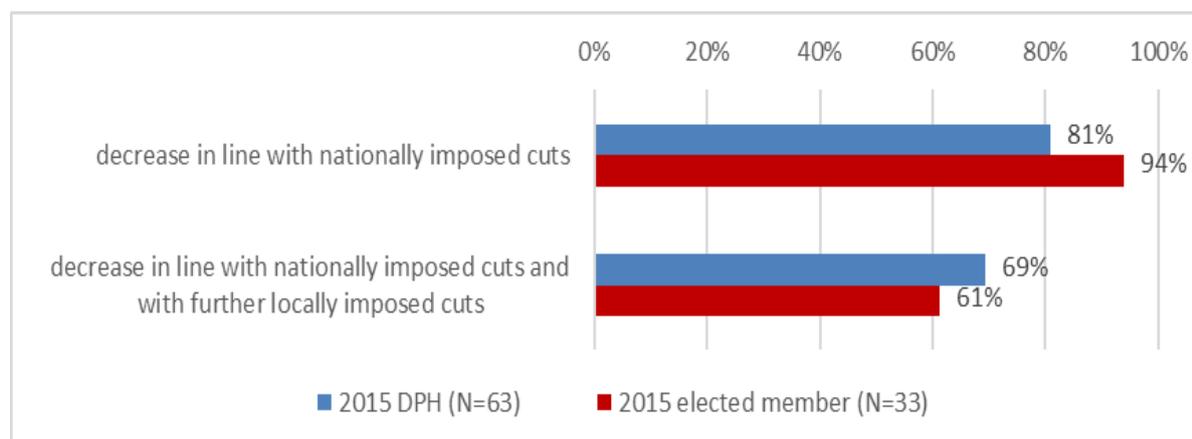


⁷ It was believed at the time of our interviews and surveys that the ring-fence would be removed in April 2016. However, the Chancellor’s November 2015 budget statement announced that the ring-fence would remain until April 2018.

Whilst the public health budget was being used fluidly, the allocation of a ring-fenced budget was nonetheless seen as useful by public health interviewees. An interviewee in Site D suggested that public health ring-fencing meant they had an allocated budget and were not left ‘scrabbling’ around for funds – as they were in the former PCTs, where public health priorities and PCT priorities were not always well matched.

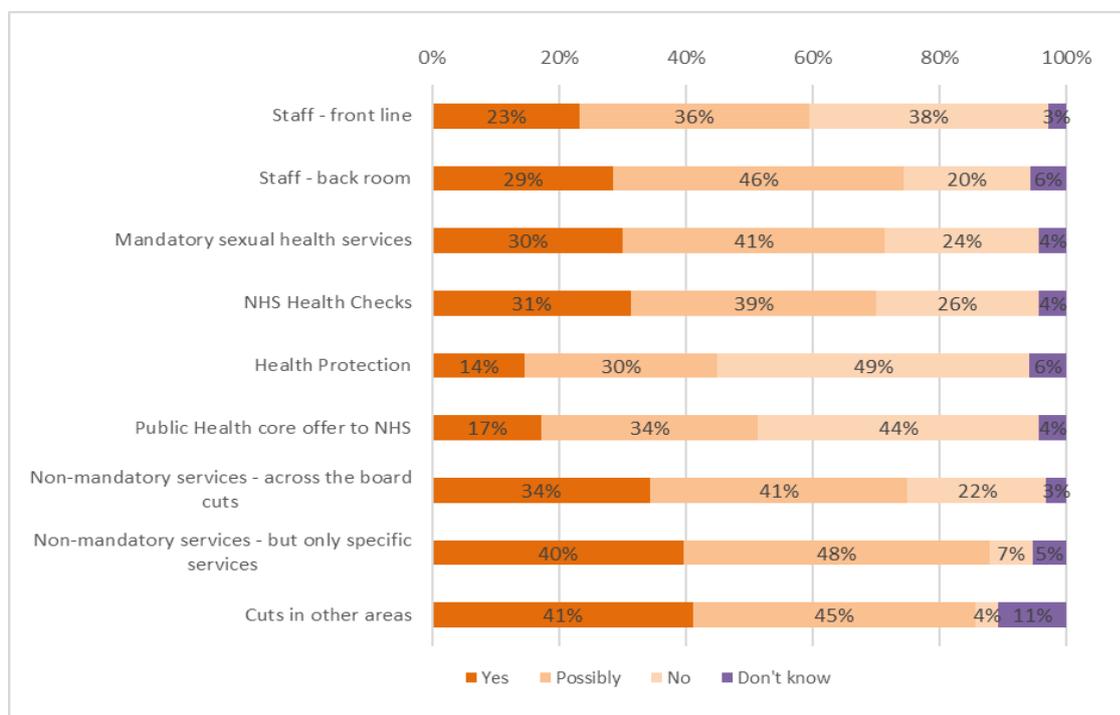
New questions in the 2015 survey asked about the LAs’ plans in the light of the removal of the public health ring-fence, and forthcoming cuts to public health funding. The majority (94%, N=70) of DsPH and elected members (91%, N=35) said their authority had not made a commitment to protect the level of public health spending when the ring-fencing was removed. The six authorities (four from the DPH survey and two from the elected member survey) who *had* made a commitment were all unitary authorities (none in London) with populations of less than 450,000, and all four DsPH were on the senior corporate management team. Most DsPH (81%, N=63) and elected members (94%, N=33) expected expenditure to decrease in line with the 6% nationally imposed cuts, and around two thirds (69%, N=62, and 61%, N=31, respectively) expected further locally imposed cuts to expenditure (See Fig 6).

Figure 6: Do you expect expenditure to decrease in line with nationally imposed cuts? (2015 only)



Comments from DsPH suggested that the public health budget will be expected to contribute to the overall savings that councils need to make, whereas some elected members felt it was too early to be certain of that. When asked where the cuts might fall, there were some differences between the views of DsPH and elected members (See Fig 7). As shown in Figure 7, for DsPH, cuts in non-mandatory services and ‘other areas’ were thought most likely (40-41% said ‘yes’), followed by NHS health checks, mandatory sexual health services and backroom staff (where 29-31% said yes); cuts to the public health core offer to the NHS and health protection were felt to be least likely (44-49% of DsPH said they did not expect cuts), although many DsPH said cuts in all these areas were possible (30-48% said ‘possibly’). (Percentages for these questions were based on N=58-70).

Figure 7: Have you identified areas to be affected by cuts in the public health budget? (2015 DsPH survey N= 64-70).



Note: the figure shows responses to several questions and some respondents did not answer all the questions. The consequent range in N is small and has little impact on confidence intervals.

Fewer elected members than DsPH said where they were expecting cuts and they were more likely to say they did not know, however, elected members agreed with DsPH that cuts were possible across the whole range of areas the survey asked about. Elected members were less convinced than DsPH that back room staff, the public health core offer to the NHS and health protection were safe from cuts.

4.2.3 Information / intelligence

Information resources, and access to information, suffered during the transition period and took a while to improve. The impact of the reforms on information resources was a concern voiced by stakeholders prior to the HSCA12 being passed, with fears of public health intelligence being fragmented and the work of public health networks being lost.

In the later phase of the research, it became apparent that other directorates within some councils were becoming more aware of the value of public health data and information as evidence. In site C, for example, public health had developed a good working relationship with licensing, and had worked positively on a campaign on the issue of legal highs, where public health provided intelligence, had contacts and could use publicity to good effect. In site D, the transport team in particular embraced the use of public health data to help target their interventions, and understood the necessity of doing this in financially constrained times. And in sites C and E public health data (such as the child measurement data) was used as input to the supplementary planning documents (SPD) on hot/fast food takeaways.

There were other advantages brought about, not necessarily by bringing public health into LAs, but by bringing multiple public health departments into one. For example, in one of our sites, three former PCT public health teams have become one team. They recently recommissioned obesity services in their jurisdiction from one provider rather than from the three different providers they used before:

" we wanted a uniform service based on the best evidence of what it should look like, and have it all in one place, with one provider, it makes it very clear" (public health officer).

Similarly, two former PCT public health teams in another site, after becoming one team working across the whole county, conducted a wholesale review of the varied weight management services, previously provided by a multitude of different providers, and intended to recommission to provide a more uniform, evidence-based service.

There were signs in several sites that since the reforms, some public health networks were disbanded and some linkages lost:

'So I used to sit on a childhood obesity group...That no longer happens since it became part of the Local Authority. So I don't really feel...I feel that I had partnership and I was a key partner in the past but I don't really feel that I sit round any table now, although we've tried...' (Non –public health Manager)

The fact that large areas of work (for example, school health improvement) were contracted out by councils, meant that it was often the contracted providers that needed to be working closely with other council departments (e.g. education). This did not necessarily appear to be facilitated by the commissioning department being within the council. Indeed, with regards to working with schools, several interviewees in both providing and commissioning organisations highlighted other policies (like the increase in free or academy schools, the removal of the healthy schools programme and the end of the 'healthy child matters' programme) which have reduced the LAs' involvement with schools. It was felt by providers that in the light of these other policies, the transfer of public health into LAs lacked in consequence. However, a public health commissioner in Site A felt that there *are* benefits to the provider (a community NHS trust) being more strongly linked to the council. She felt she was able to work with the provider to develop ways of them better linking with other professionals at a local level, such as 'early help' and 'troubled family' workforces. There were multi-agency local operational groups that could help with coordination, and there were school-based and district-based health plans which could be used to help identify priorities at local level.

An interviewee from a community NHS trust providing public health services in site A felt that she had lost a lot of the partnership working in the initial transition. She said she used to sit on a lot of partnership groups/locality groups before the reforms. In some cases, these groups no longer existed, and in other cases it was more that her focus had narrowed – to provide a service she was commissioned to provide – so that it excluded some of the networking she used to be engaged in.

This experience was echoed by a dietician in one site who lamented that she was no longer involved in particular groups:

“...because I used to be one of the food futures steering group members, and then it was just food board meetings; I’ve not heard anything, to be honest I’ve not seen anything, so I’m not saying they’re not happening but I’m not seeing the outcomes of that”.

A respondent from another site noted that the obesity partnership mentioned previously, had been disbanded when public health moved into local government:

“... [The DPH] disbanded a group that were meeting linking all of those services. It wasn’t just about paediatric weight management, it was about the obesity agenda in general and...[they] didn’t like it because, quite rightly, it didn’t have a targeted...a focused enough agenda but it was an incredibly valuable meeting point for people with a shared interest”.

Our data suggested that some former public health networks have been disrupted, with a potential threat to local public health information/intelligence.

4.2.4 Supporting structures and processes

When we examine what is required to enable effective use of the staff, infrastructure, skills and tools available, then aspects of leadership and governance become important. Our data suggested that leadership of the public health agenda was more dispersed within LAs, with elected members taking a clear role in helping to decide priorities and strategies (Peckham et al 2015). Depending on a variety of factors, such as the character and interest of the elected members, the internal organisation of the council, the cooperativeness of other directors, and so on, DsPH might face different experiences with regards to their authority and independence to make decisions. This is likely to be most acute in the health improvement domain of public health, as opposed to health protection and improving services, which are more easily understood to require specialist/clinical knowledge. In the best situations, public health professionals might be motivated, inspired and empowered to develop and implement new ideas. In site B, for example, the elected member with the health portfolio was particularly passionate about childhood obesity. She invited the incoming public health team to think not about what they *had* been providing, but about what they would like to/need to provide to bring about real change in outcomes. She encouraged the team to think innovatively, and met the team’s response with a significant additional investment into this area.

Also in site B, there was work being undertaken to raise the profile of public health within the council. Here, they were progressing a "whole council approach" idea, which aimed to utilise LA skills and levers, and ‘sell’ public health priorities to the LA. Initiatives included a tool to help the LA think in a more public health way, a fund to enable people from the whole council to submit ideas for new projects with a public health focus, and a transformation board to help public health embed across the council. The strategic aim of the public health team in this council was *“to have health in all policies”* (public health officer).

Our surveys showed that since 2015, there had been an increase in the number of authorities with a requirement for other departments always to collaborate with public health on their plans (34%, N=67 in 2015, compared to 15%, N=85 in 2014) - a shift that was echoed in the subset for which we could make year on year comparisons. As already mentioned (section 4.1.2) the surveys attributed successful integration of public health to strong leadership, high quality staff and PH working right across the organisation, factors which had helped to break down the barriers due to differing working cultures.

In the worst situations, public health professionals might be restrained or restricted, perhaps through lack of resources (evident in all our sites), lack of freedom (to innovate or make their own decisions), or perhaps by a lack of support/interest. In site A, a public health specialist was particularly passionate about reducing smoking. However, she was frustrated by the lack of political interest/will to do anything other than deliver individual stop-smoking services. In one of our sites, a newly recruited DPH left after feeling restrained by a dominant senior director to whom they were managerially accountable. Our data suggested that having strong councillor and senior officer support (as in site D), or not as suggested in another of our sites, could have a significant impact in terms of programmes being protected and the ring fence not being 'raided'.

One example of potential capacity restraint could be the extent to which the DPH has full power to authorise expenditure from the public health budget. In the surveys, comparing 2015 with 2014, there was a small increase in the proportion of DsPH saying it was them alone that authorised expenditure from the public health budget (66%, N=70 in 2015, compared to 58%, N=85 in 2014), with only very few saying it was in the hands of others (4% in 2015, compared to 14%). In the subset of LAs where we could see year on year change, nearly a third of the DsPH responses indicated that there had been changes in who authorised the public health spend. Another example could be the extent to which the DPH has influence over other departments' expenditure. In the 2015 survey, 13% of DsPH (N=70) and 21% of elected members (N=33) said DsPH had 'quite a lot' of influence over other departments' expenditure, whereas 39% of DsPH and 30% of elected members said DsPH had no influence.

In several of our sites, it was apparent that the upheaval of the reforms had had a negative impact on the strategic leadership of the public health team – particularly where there were DPH vacancies for a period of time. In two of our sites, there was a suggestion that there was a lack of strategic direction for public health and that this in turn was having an impact on the way public health was perceived by others within the LA and in site B, on team morale and retention, as this quote illustrates:

"We have lost some of that strategic direction and that has a knock on effect on the team, the team wants and needs stability, so there is a knock on effect on morale and retention. We need strategic direction" (public health consultant)

A lack of clear strategy, it was argued by one interviewee, had left public health weak, rendering them reactive to other directorates' requests, with no strong rationale to say no, such that they have

“just been drawn into things that haven’t been ideal with no support really, no leadership to say, no we’re not going to do it.” In this instance it was also felt that a clear strategy would also have enabled public health to present a case for protecting its budget.

One aspect of leadership and governance is the management of accountability. Elected members clearly have a strong scrutiny role, and for one elected member in site A, this meant that public health were beginning to be a lot more specific about what they were trying to do. However, a stronger focus on limited central measures of performance might fail to take into account that there are multiple influences on the health choices individuals make. This non-public health manager was sceptical about some policies adopted by public health professionals: *“...there’s also this patronising attitude that people just need information, well they don’t...”* They argued that public health officers needed to involve councillors more because they know their ward and have their ‘ear on the ground’ as to what is going on in their area. Another non-public health manager argued that public health do not understand how LAs and councillors work and used smoking cessation as an example:

“The worst thing you can do to a councillor, if the councillor says, I want to do something about smoking, what more can we do? You don’t want a public health person saying, well we’re doing all the evidence based work, there’s nothing more we can do, because everything else would just be guess work, but that’s what some people say”.

There were signs of frustration in site A from public health providers who were feeling the pressure to demonstrate the achievement of specific outcomes being passed on to them via the public health commissioners. In a fragmented system, and with complex health issues, the achievement of health outcomes depends on a wide range of actors playing their part. A manager in a provider trust explained that much of their work in preventing childhood obesity is underpinned by developing good relationships with schools, and engaging them in the agenda. This takes a huge amount of their time and energy, but is difficult to evidence in terms of outcomes:

“That’s for me part of that struggle at the moment because we’re commissioned very much around... or looking at outcomes and, you know, how do you prove the worth of that? It’s very difficult in the world in which we live.” ...

“So part of a piece of work that was done recently by a consultancy for [the council] was asking us specifically how much time do you spend, how much does it cost, and what’s your unit BMI reduction across all of our services. Now absolutely from a tier three on my adult weight management, we should know the answers to that, but you can’t do it for the others. ... If they’re looking at those outcomes you’ve got to almost commission a clinical-type service - which sits quite comfortably with me as a dietician - you know, I’m quite happy with that - but that’s not public health” (Provider).

4.3. Public health activities

As mentioned in the introduction to this section, public health activity was expected to change to include a greater emphasis on the wider determinants of health, to incorporate a broad view of what services will impact on the public’s health, and to combine traditional ‘public health’ activities

with other activity locally to maximise benefits. Public health activities will be determined in part by a process of needs identification and prioritisation, and the development of strategies.

4.3.1 Prioritisation

In terms of determining public health priorities, the field is open to a greater range of decision makers within LAs, including elected members as well as public health experts. This means that there is more of an opportunity for priorities and activity to be driven by local 'granular' knowledge (by virtue of elected members having 'soft' intelligence of their local ward constituencies), as well as by local politics and the ideology of an elected member and/or the controlling party. We saw some evidence of the influence of elected members on priority setting.

In the surveys, elected members were asked the extent of their influence over the priorities of the LA and also for their influence over the public health team. Results for elected members were similar in both rounds of our survey with few councillors reporting that they were not able to influence public health priorities. For example the results in 2015 showed that 43-45% felt 'always' able (N=37 and 38), nearly half 'quite often' able (N=37 and 38), and 8% 'not often' able (N=37 and 38) to influence priorities of the authority and the public health team respectively.

Within our case study sites, an elected member with the public health portfolio in a Conservative council explained how members might sway priorities in a more subtle way:

"tobacco is one issue which probably would not appeal to that many Conservatives. They're not particularly interested in it, they think it's a pretty... 'oh well if people smoke themselves silly, let them smoke themselves silly' ... So if I tried to put forward lots of measures which are going to rapidly and massively increase spending on tobacco and cigarettes, I'd have to work quite hard for that. Interestingly however, drugs and alcohol is something which they are very interested in".

He subsequently explained that the interest in drugs and alcohol came from an antisocial behaviour perspective, rather than a health one. He explained that he got *"a bit less support actually in things around like obesity ... obesity I have to work quite hard at"*. In this site, the elected member for health appeared slightly out of kilter with his fellow cabinet members, and positively championed those issues which otherwise might be difficult to get on the agenda.

4.3.2 Strategy development

The key public health priorities as identified through the joint strategic needs assessments are likely to be consistent with those identified prior to the reforms. However, with the identification of a defined public health grant (which did not exist prior to the reforms), there were opportunities to set those priorities against the allocation of spend across the various services commissioned/provided by the public health team. This was enabling public health teams and their LAs to be a little more strategic in terms of defining their intended portfolio of services.

Elected members and other senior officers in the council did seem to be playing an active part in the development of strategy around how to improve health. In our survey, elected members were asked if they would like to see their LA change the way it went about improving health. The results shifted from the majority in 2014 saying ‘no, I think we have got it about right’ to two thirds saying they want to see change a year later (66% N=32 in 2015, compared to 45% N=44 in 2014). Only a few comments were made to expand on this, suggesting that public health should be mainstreamed across the authority, and that public health staff should be less territorial about how their budget is spent. The shift towards wanting change may be influenced by the fact that there were more elected members in the 2015 survey (30% N=47, compared to 10% N=51 in 2014) who were new to the health portfolio.

LAs also bring a level of scrutiny, informed by over fifteen years of implementing best value⁸, which is different to that found in the NHS. In some of our case study sites, this prompted questions to be raised and reviews to be conducted. In site A, for example, the leader (in 2014) explained their approach as a council to thinking about the non-statutory public health spend:

“Well, so there we’ve got to start at reviewing is that delivering to the right priorities or not? Is it value for money or not? And what should we stop doing and what should we start doing? And we’re at that stage of analysing what’s gone on and starting to have the big conversation about whether or not they’re successfully delivering the outcomes for which that money is intended. And I think the answer is probably certainly not in many, many cases”.

In 2015, the public health team in that council conducted a comprehensive review of their department to answer a series of key questions, including “do we invest our grant in the right way?” (internal case study document). This was leading to wide changes in what services were commissioned and how they would be delivered.

Freedom to pursue different approaches – and particularly ones that seek to tackle socio-environmental determinants of health - will depend (at least in part) on the core understandings about the causes of public health problems, and how they should subsequently be tackled, amongst key council decision makers. These core understandings might determine strongly the approach taken to a problem, and it might be unreasonable to expect these understandings to shift to any great extent, particularly where there is such dominance of particular discourses – for instance, that obesity can be effectively ‘treated’ through lifestyle change. Understandings of the problem shape

⁸ Best Value Statutory Guidance of 2011: “Under the Duty of Best Value, therefore, authorities should consider overall value, including economic, environmental and social value, when reviewing service provision. As a concept, social value is about seeking to maximise the additional benefit that can be created by procuring or commissioning goods and services, above and beyond the benefit of merely the goods and services themselves”. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/5945/1976926.pdf

the way in which responses are thought about and constructed. This councillor, for instance, discussed health inequalities across his authority; he stated that:

“our big challenge is health inequalities and above all else reducing health inequalities is the big thing we’ve got to focus on”.

He went on to give an insight into his understanding of the problem. He explained that in their more deprived wards:

“People don’t know how to stay healthy, people don’t go for tests, people don’t... If they’re told to go to the doctors they don’t bother going”.

The leader of the same council also talked about his understanding of the same problem (inequalities). Talking about those living in the more deprived wards, with lower life expectancies, he said:

“a lot of those that die early haven’t been to a doctor for regular check-ups so... and they’ve never been prescribed hypertensive drugs and they’ve never been prescribed statins, so they walk around at the age of 55 with high blood pressure and furred up arteries because nobody’s ever put them on statins and surprise surprise they have strokes and heart attacks”.

This rather bio-medical understanding of the problem of health inequalities prompts a particular response, essentially geared around ensuring people in these deprived wards access their GP.

A non-public health manager also demonstrated ideological differences and was somewhat scathing about the approaches adopted by public health professionals in tackling health inequalities in deprived areas:

“...put them [public health professionals] in a room, and they come up with lots of fancy ideas. It’s all the fancy ideas, they’re very middle class. Like, why don’t people give their children pasta with a sprinkling of parmesan and pesto and that sort of thing? The answer is because they haven’t got any parmesan in the fridge, they haven’t got any pesto in the fridge, the chip shop is flogging three lots of pie and chips for a fiver, and that feeds the kids... the interventions that they try out, would work on them, because they live in a four bedroomed detached house with a couple of BMWs...”.

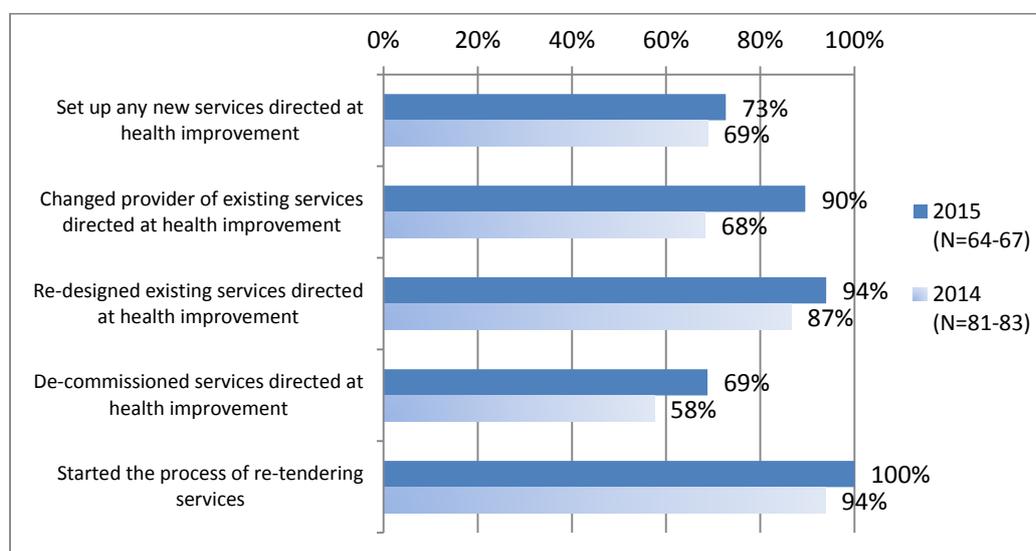
4.3.3 Commissioning, providing and other activities

Some LA public health teams have taken a long time to sort out the contracts that moved across from the NHS. There were some disagreements about who was responsible for what, which were made all the more important in the context of tightening budgets. Many of those contracts that moved across to the councils were since subject to new scrutiny, leading to countless service reviews and commissioning and contracting changes. Public health practice, then, with respect at least to which services are commissioned and from whom, has seen some changes. In one of our sites, for

instance, the council public health team very quickly decommissioned a tier 3 obesity service, on account of there being poorly evidenced outcomes. The lack of clarity around roles and responsibilities, the fragmentation and disruption of the system, and the continued changes (for instance, with the later transfer to LAs, in October 2015, of services for children from 0 to 5) have meant that gaps have been created, through which certain services might fall.

In the 2015 survey, the proportion of DsPH reporting that they had made changes to services commissioned under the ring-fenced public health budget in the last 12 months remained very high at 96% (N=67 compared to 94% N=83 in 2014).

Figure 8: Has your local authority made any changes to services commissioned under the ring-fenced public health budget? (2015 and 2014 DPH national surveys)



Note: the figure shows responses to several questions and some respondents did not answer all the questions. The consequent range in N is small and has little impact on confidence intervals.

Beneath this headline, the types of change the survey asked about had all occurred more in the year leading up to the 2015 survey compared to that reported in 2014 (see Fig 8). Re-designing existing services was most commonly reported (94% had done this in 2015, compared to 87% in 2014), and considerably more DsPH said they had changed provider (90% in 2015, compared to 68%). 73% (69% in 2014) had set up new services and 69% (58% in 2014) had de-commissioned services. The same patterns of change were seen in individual authorities that could be compared year on year.

The high proportion of DsPH reporting that they had set up new services, alongside the high proportion reporting that they had decommissioned services, indicated that there was real change happening (rather than just services being cut). Our case study work provided further insight into the extent to which and how activities/services were changing. In site B, we were told that public health professionals now had more freedom to think differently:

“what’s interesting from discussions with various councillors is that the ones who are switched on – and I think most are – are basically saying, the bottom line question is, okay, public health are here now, what’s going to be different? ... And one conversation I had was about public drinking fountains. You know, a very simple idea but what effect could it have on childhood obesity? You know, if kids are drinking more water they’re probably buying less fizzy drinks. Also on dental decay. So is that a simple public health measure that we could just try and make happen?”

The same public health respondent elaborated further:

“So that challenge is there. You know; what are we going to see that’s different? ... Will we see more 20 mile an hour zones because it reduces accident rates? Will we see more cycling? You know, cycle lanes is the obvious one. Will we see... everyone’s standing outside smoking – will that... will people be... will there be an exclusion zone? What will it be? What we will we start to see? Will there be less... You know, the other obvious one; fast-food outlets outside schools. Will we discourage children buying chicken and chips on the way home by giving them an apple and a banana as they walk out of school? You know, all of these things. What will be seen as a good challenge? And I don’t think the NHS ever asked that”.

In site C, a public health respondent talked about how they “... decided to move away from individual lifestyle services ...” Towards the latter part of the research period in particular, there was a sense emerging from our case study sites of the importance of a ‘whole system approach’ or holistic approach to the wider determinants of health in the locality, and of the opportunities afforded for this by being in the LA. This is a message that has been heavily promoted by PHE, who recently co-funded a programme to research, develop and pilot a ‘whole systems approach’ to tackle obesity.

Consistent with this, in site A’s county council, this elected member talked about the desire to think about public health activity in a different way:

“what we’re trying to say almost is here’s a public health issue but a big part of delivering it is not actually going to be done by the health service or indeed public health in that sense. You know, it’s a matter of... of... of district policy, for example, around the areas of, you know, is it desirable to try and have a different licensing policy vis-a-vis the number of fast food outlets you have, how close they might be to schools and so-on and so forth”.

However, it felt as though that shift might have been tentative and slow. When asked about whether different approaches were actually being delivered he said:

“Well there’s been... there’s been... there’s certain elements... Certainly in terms of things like trying to find a boost to, you know, walking and cycling and all this sort of stuff. I mean there’s been sort of that but I suppose the question in part is, you know ... are we being radical enough? I think... I wouldn’t put it any more strongly than this but I think there’s a willingness to ask the question quite a bit”.

In this council, the public health team explained that they were trying to increase their “breadth of impact in local communities” (DPH), partly by encouraging partnerships between traditional service providers (such as NHS) and others (such as housing associations or other third sector organisations).

But their emphasis at the moment remained largely on getting (the 'right') people into individual-oriented lifestyle change programmes:

"So we'll be expecting... And it may be that, you know, a provider will come forward with housing associations alongside the voluntary sectors and they'll all be working together to create this network that gets... sucks people into the smoking services, whereas at the moment we don't have that at all." (DPH, site A)

In site C, interviewees also spoke of a shift in approach being undertaken, as this public health officer explained:

"We've had too much of a focus in our team on commissioning services, from a public health perspective, rather than thinking about actually balancing our role, and thinking about our leadership, and that's the more strategic role. So I think the idea is that commissioning is part of what we do, but it should only be a part of what we do, not all of what we do. And I think because the way PCTs had evolved over a number of years, it had very much become a commissioning focus. So, people are happy if they can commission a service for a person, where you can count it, and actually that's not what we should be doing in public health, or not all of what we should be doing. So the rationale [for the restructure of the team] really was to make sure we're fit for the future, make sure that we've got the right balance between our commissioned services and our leadership, and policy and strategy development."

An example of the shift in approach in one site was described by several members of the public health team as moving away from weight management services towards integrating various elements into promoting health and wellbeing and thinking about "clustered lifestyle behaviours", and incorporating "community capacity building as being a fundamental part of that approach going forward". This shift in approach entailed making significant decisions that very much altered the activities in the area:

"So when we looked at the value for money stuff, it ranged from £75 to £6000 for a successful weight loss intervention. And so what we did was we literally...we just decommissioned all those services and put all the money into one big pot with a view to commissioning much more holistic lifestyle services, but also we'll take account of somebody's social needs, so what we were saying was, if you talk to the communities that we want to reach, who are maybe drinking too much, smoking, not taking enough physical activity, and not eating a healthy diet, actually they're the last things on their list of priorities, because what they're concerned about is their bedroom tax, their housing, and their benefits. So, actually, they're not even pre-contemplation in terms of behaviour change really, and what we were hoping to do, is if we work holistically with those people and support them with whatever their needs are, where they're at, that we can nudge them towards contemplation and then potentially behaviour change" (PH consultant, site C).

This approach was a move away from one that was solely about individual behaviour change programmes. The DPH described how the approach was:

"using existing council resources in a very different way, so it'll be tapping much more into community assets resources, bringing to the added value of all the things the council can bring to the table, whether it's volunteer support programme, the use of libraries, community

facilities, neighbourhood development work, countryside volunteers, where we use green space ... We've also created greater links with the transport planning process and feeding in much more strongly on the public health agenda there, looking at some of the issues around community safety, standardising speed limits in certain parts of [the borough]" .

Within our case study sites, we explored the extent to which public health teams were working with others across the council. Despite often voiced issues of personnel capacity, and the difficulties of working with planning mentioned in the above section, in site C, political desire (prompted by councillors), coupled with the importance of the health aspect, meant that planning and public health worked together to get a SPD to restrict the number of fast food takeaways. The planning officer in this site talked about further scope for working with public health, and they were co-producing planning strategy documents where there were health related aspects. In a unitary authority within case study A, considered alongside the county council, some detailed work was done by a public health officer on the scope for tackling obesity through the built environment, and they subsequently implemented a number of actions to improve integration.

In site D, the chief executive of one of the district councils explained that they were taking various actions to try to encourage public health and planning officers to work together. The chief executive showed leadership on this, and had attended the planning officers' forum with public health consultants. They have ensured that district officers – a housing person, an environmental health person and a planner – have joined the Joint Strategic Needs Assessment (JSNA) working group, so that *"hopefully the JSNA can then be feeding into the local plans for core strategies"* (chief executive, district council). They have set up training for planners (not just the managers) to inform and "energise" them to think about their role in public health improvement, and to bring in some of the work that PHE are doing on planning and public space. They also talked about getting a public health person to regularly sit on the planning officers' forum, which was where the planners meet once a month or so to talk about traffic and land use, and housing, and so on. Further examples of how activity was changing, and what was influencing those changes, are discussed in section 6 with regards to obesity.

4.4 Summary

LA public health teams have been largely preoccupied with developing the structures and processes required for effective operation. While this finding was not unexpected in earlier phases of the research, our findings demonstrate that this continued even after two years. In some cases, this has meant re-thinking the skills and skill mixes required, with several of our case study public health teams concentrating on bolstering their business management/commissioning skills, and concentrating less on more 'traditional' public health skills. The organisational position of the public health team and the DPH were important in terms of ability to influence strategic decision-making and work with other departments.

Within LAs, contracts have received new scrutiny, and both existing and new contracts have had to be negotiated with providers, within a new more unsettled provider landscape. In addition, actors within the system had to negotiate ways of working with other actors, in a situation where much

was new. The situation in two-tier council areas created additional complexities of inter-organisational working (discussed in the next section).

As a backdrop to all of this, the insecurity in the financial situation added a significant nuance. LAs were sometimes unsure of the details of their financial settlement from government until after many contracts had been negotiated, leaving them with few areas in which to make cost savings. This could leave some types of activity more vulnerable than others. The even harder-hitting budget cuts across other departments within LAs also brought additional pressures to public health teams, as costs were transferred and cuts shared across departments.

5 Inter-organisational relationships across the new public health systems

A key goal of the restructuring of the organisational arrangements in England was to improve the co-ordination of public health functions. The establishment of PHE was to consolidate expertise, intelligence and advice in one organisation responsible for advising and informing the NHS, Government and LAs, leading to a strong and clear national approach to protecting and improving health and to addressing health inequalities. The shifting of public health responsibilities from the NHS into LAs aimed to develop strong local political leadership and better integration between health, social care and public health. LAs were charged with creating HWBs to bring together the NHS, public health, adult social care and children's services, including elected representatives and local healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.

This section reports on findings from our research related to the policy goal of creating a more joined-up system with clearer leadership, and the subsequent expectation that, as a result of this improved co-ordination, there would be a reduction in overlapping responsibilities, reduced inefficiencies, and the exploiting of synergies across services. At a local level, this would mean a community-wide approach to protecting and promoting health and wellbeing. We begin this section by examining the key organisations within the new public health systems and their inter-relationships. We then explore key functions across the system in terms of identifying priorities, developing strategies, and organising to deliver services. Finally, we consider the extent to which these functions are co-ordinated across the system, and how.

5.1 Organisations and their inter-relationships

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, all saw fundamental change. The changes have dismantled existing partnerships and time and effort has been required to build and even re-build partnerships.

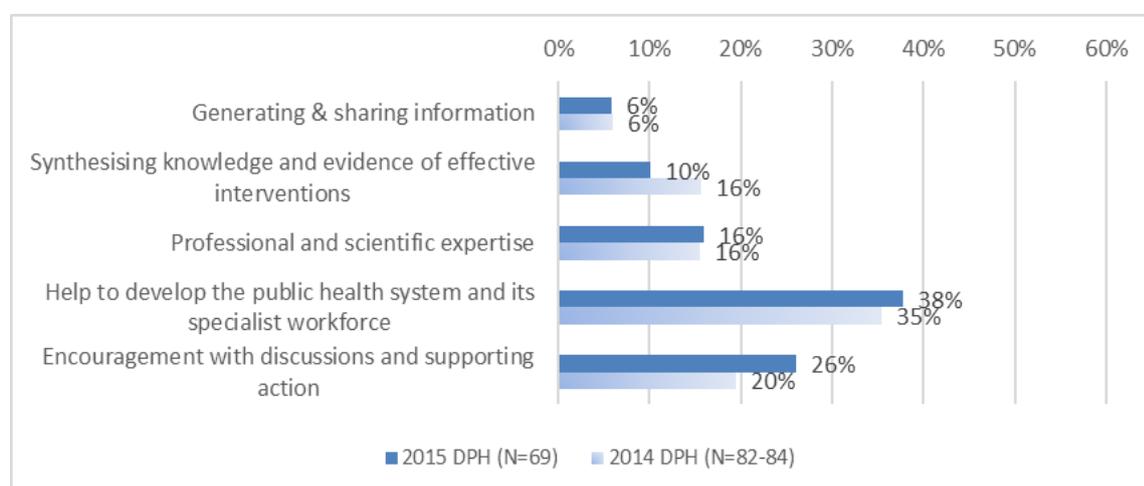
In our interviews in 2013/14 respondents referred to the removal of many of the mechanisms for and emphasis on performance management emphasising that the new system relied heavily on *'leveraging'* – exerting influence without direct levers. As we stated in our first report, it was clear to several informants that the only way to *"leverage the system to implement and drive impact ... is to build strong and effective relationships and networks."* (Gadsby et al 2014: 8). There was a significant focus on relationship building in the immediate period following April 2013, but many respondents interviewed in 2013 and 2014 within LAs, NHSE, CCGs and in PHE highlighted that given the extent of organisational change, 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. In section 3, we began to tell the story of how the different elements of the public health system have developed since April 2013. We highlighted how long it has taken to organise and develop public health structural capacity and roles and relationships in relation to public health practice. Organisations key to public health

action in the new system include PHE and NHSE at the national and regional levels, and LAs, CCGs and a host of provider organisations at the more local level.

5.1.1 Relationships with PHE and NHSE

Some inadequacies of the system design have already been highlighted in section 3, with regards to clarity of roles and purpose, in particular for PHE. However, positive relationships do seem to have developed between the majority of DsPH and members of their local PHE centres. In our 2014 survey, 72% of DsPH (N=78) said they had received a good or excellent level of support. The 2015 survey did not include the opening questions about support, but repeated the more specific questions asking if support was received from PHE across several areas of information provision, expertise, development of the public health workforce, and other forms of encouragement and support. The survey results showed there had been small changes in the different kinds of support received from PHE, but with no clear overall improvement since the 2014 survey. In 2015, the most common answer remained ‘yes to some extent’ for both DsPH and elected members. No more than one in five DsPH felt ‘yes fully’ supported. The proportion who said they were not or ‘not really’ getting support from PHE in these areas was quite high for developing the public health system and its specialist workforce (38%, N=69) and providing encouragement with discussions and supporting action (26%, N=69). (See Fig 9).

Figure 9: In your work to improve public health, do you get the following support from PHE? - % saying no or not really (DPH surveys)



Note: the figure shows responses to several questions and some respondents did not answer all the questions. The consequent range in N is small and has little impact on confidence intervals.

As in 2014, when asked what value the local PHE centre added to the public health team’s work on improving health and reducing health inequalities, comments within the survey from DsPH in 2015 showed that there was good over-arching support and excellent support for health protection, but views on data and intelligence were mixed, with some saying it was limited or did not provide direct help with local issues. One DPH from our case study sites commented:

“To be honest, the relationship with PHE feels very very peripheral, I don’t think we’re very, we don’t interact hugely with PHE. Our intelligence team is part of [a wider] knowledge and information network, but that’s about it from my perspective anyway” (ite B).

The survey asked what help they would like in the future and from whom. Nearly three quarters added a comment and many DPH responses stated that they would like to have a better working relationship with PHE and a more joined up approach would be beneficial. DsPH wanted help in the form of stronger public health leadership and expertise, advocacy and support for public health policies both nationally and locally, as well as better access to data and modelling tools.

Our survey of elected members found that they mainly did not know or thought there was little support from PHE, but some valued the collaboration and learning opportunities that PHE had organised.

The direct role of NHS commissioning organisations with regards to some areas of public health activity has been very much reduced. However, they remain a vital part of the jigsaw; the success of much public health activity commissioned or delivered by the councils relies significantly on the contribution made by NHS providers and commissioners. The NHS commissioning organisations themselves – NHSE and CCGs – are relatively new, and so have focused on organisational forming and establishment. This process is inherently more inward than outward looking.

From our data, relationships between council public health teams and NHSE England appeared to be largely confined to health protection issues. However, as already highlighted in section 3, the fragmentation of responsibilities has made inter-relationships more complicated. In a discussion of their relationship with NHSE, this public health respondent from site E commented:

“I think with NHS England, because one of the things - colleagues are having a meeting tomorrow - we’re responsible for commissioning school nursing, but then the CCG is responsible for commissioning special schools’ school nursing, and then NHS England is responsible for commissioning immunisation programmes for children in schools, you know what I mean? It’s like split up”

5.1.2 Relationships with CCGs

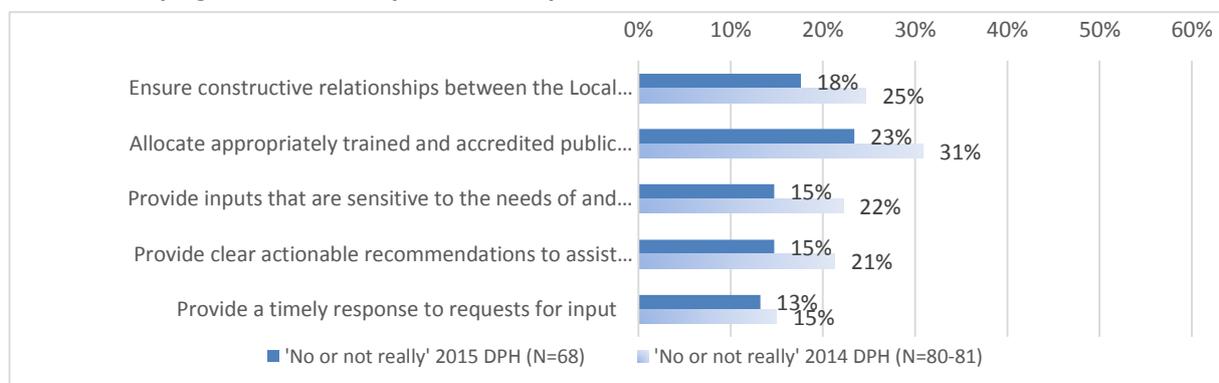
The relocation of public health staff into LAs has clearly separated public health from more clinical colleagues, which some NHS staff and some public health staff were finding difficult to adjust to. In our 2015 survey of DsPH, when asked about the extent to which they felt able to deliver real improvements in local health by influencing the work of the local CCG(s), 48% (N=67) of respondents felt ‘less’ able than before the reforms (this compared to 37% reporting that they felt less able in 2014 N=83).

However, each public health team has a duty to provide support and advice to the CCGs in their area, and this was generally achieved by having nominated public health consultants linked to each CCG. In the surveys, DsPH were asked about the services they provided to CCGs. The 2015 survey

responses showed a similar pattern in the number of CCGs that the public health team supported, with 64% having one CCG, 10% having two CCGs, and the remaining 25% (N=67) supporting between three and seven CCGs. There was an increase, between 2014 and 2015, in the proportion of DsPH saying they had provided various kinds of support to CCGs. In the 12 months prior to the 2015 survey, nearly all public health teams had provided help with planning/assessing needs (99% N=68 in 2015 compared to 100% N=82 in 2014), reviewing service provision (97% in 2015 compared to 88%) and deciding priorities (96% in 2015 compared to 85%). There had also been increases in the proportion that had helped with monitoring and evaluation (82% in 2015 compared to 73%) and procuring services (54% in 2015 compared to 40%).

Questions on the capacity of the public health team to provide professional support to CCGs across a range of activities suggested that overall, there had been some increases in capacity: fewer DsPH saying they did 'not really' have capacity and more saying 'yes – sometimes' they had capacity. However, a different picture emerged in the authorities where we had year on year data, as the responses shifted away from saying 'yes – always' to 'yes – sometimes' when respondents reflected on whether the capacity of the team was sufficient to be able to provide the five specified areas of support to CCGs (DH 2012d). Analysis of the year on year comparison dataset showed that they were no different to the overall sample in terms of the number of CCGs they were supporting. A closer look at the overall results showed the reduction in the proportion with full capacity had also occurred but to a lesser degree, and it was concluded that the shifts had been from the extremes of the response scale towards the middle. Public health teams having capacity to support CCGs 'sometimes' had become the more usual situation (said by 52-65% of N=68 DsPH responding to these questions in 2015, compared to 41-56% N= 80 in 2014). Between 21-29% of DsPH responding to questions on support (compared to 28-32% in 2014) said they 'always' had capacity to provide the different types of support the survey asked about, and between 13-23% (15-31% in 2014) did 'not really' or 'not at all' have capacity to support their CCGs (See Fig 10). Public health teams in two-tier authorities appeared to have fewer capacity issues - for example, they felt they were more able to allocate appropriately trained staff to support CCGs.

Figure 10: Is the capacity of your team sufficient to be able to provide the following support to CCGs? - % saying no or not really (DPH surveys)



Note: the figure shows responses to several questions and some respondents did not answer all the questions. The consequent range in N is small and has little impact on confidence intervals.

Relationships between public health officers (now in councils) and local NHS personnel (now in CCGs) had clearly altered since the reforms, but where there was continuity of people, it was possible to maintain relationships more easily. Public health teams in our case study areas were adopting different approaches to working with CCGs, with some having allocated time to work with CCGs, and a few joint appointments, but most were on an ad hoc basis responding to requests. Memoranda of Understanding (MoUs) were often drawn up between public health teams and CCGs, but in several cases, it was clear that these MoUs were unrealistic given the public health team's capacity and workload. Interestingly, while both CCGs (in this and other PRUComm research) and DsPH felt that relationships would improve with time, as previously noted our survey results illustrated that more DsPH felt 'less' able, in 2015, to influence the work of CCGs than in 2014, (48% in 2015, compared to 37%). A HWB chair in one of the sites felt that CCGs had become disengaged from public health:

“But I think we’ve got to persuade the CCG that, in particular, public health is everybody’s business, it’s not just the local authority’s business. ... they see public health as a separate entity at the moment, and not part of an integrated health economy”.

As we reported previously (Peckham et al 2015), key people were seen to be attending each other's meetings, and there were representatives from CCGs on the HWBs, but evidence of meaningful engagement was limited. There were, however, instances of where collaboration on a specific issue had brought about improvements. In site C, for instance, public health officers and CCG personnel each explained how they collaborated with each other to improve their approach to NHS health checks, which they counted as a positive success story. However, there were signs that it had become harder to maintain relationships between the two teams, with the loss of the 'soft' intelligence shared by corridor conversations. They had introduced more 'formal' mechanisms, such as joint appointments and monthly joint meetings between public health and the CCG, but, whilst they *are* maintaining those relationships, they have changed, as the CCG chair explained:

“We have a joint agreed work plan, whereas before we just informally worked together on key things. We have I suppose a little bit more clarity around exactly whose responsibility is whose between the CCG and public health, whereas before I think it was very much everyone just ensured it happened. So it seemed to work fine before and I guess on the whole it does work fine now. But we have to service that interface, which requires a bit of energy and therefore there’s less energy for actually doing the job”.

The CCG chair at this site also talked about the opportunities that have arisen since his CCG merged with another. Their geography now encompasses two councils, and they have both council DsPH attend their governing body meetings. This has enabled conversations that “*open up relationships between local authorities*” to enable some shared learning and joint working to happen.

Key to the changing relationships between the LAs and CCGs around public health is that there is now a direct relationship between elected members (as opposed to managers) and clinicians. A policy officer in site A explained that these relationships are developing both within and outside of the HWBs. Several of the elected members in this site talked about how valuable these relationships

were, in terms of better understanding how different elements of the system can support each other.

5.1.3 Relationships between County and District Councils

In two-tier county councils, public health teams had an additional, and very important, level of organisations to relate to: district councils. This meant that county councils had a much more complicated set of relationships than unitary authorities. As one county-based DPH with a number of CCGs and districts remarked: *“there’s a lot to be keeping up with and there’s a lot of... there’s a lot of variation just in the way things are done or who’s doing what.”*

As highlighted in previous reports (Gadsby et al 2014, Peckham et al 2015), district councils were seen to play a key role in public health. Two of our case study sites were counties with a number of district councils within them. Within counties there was an acknowledgement that district councils were closer to local communities and that it was important to work with them both from a functional perspective (planning, housing, leisure, etc.) and in terms of working with local communities. In both counties, public health had begun to engage with district councils to varying degrees, but as yet strong links had not been fully developed. As discussed in section 4, the main areas of liaison have related to some limited work on planning, active travel, housing, and around sports and physical activity.

Whilst public health interviewees reported having worked with district councils in the past, it was clear that in the new system, this relationship had been strengthened in some districts at least. However, the development of strong relationships will take time and work (which requires capacity within the public health teams both in terms of staff and relevant skills), and willingness on the part of the district councils, with a shared understanding of the importance of leisure services, housing, planning, environmental health and licensing for population health improvement.

It was clear from our case study work that council to council relationships are developing in varied ways, highlighting the complexity of these large organisations. In site A, sport activities were well developed with local leisure services, but links with planning, for example, tended to be much weaker or non-existent. In site D, links with planning in one district were very well developed, but in another district there were no links. The DPH in site A highlighted the current minimal level of contact but remained optimistic about the potential to work more closely together by developing ‘district deals’, where the public health team make a small-scale financial contribution to the district, with certain expectations attached.

5.2 Key functions across the system

5.2.1 Identifying priorities

Council public health teams’ priorities were dominated by the processes of settling in throughout the transition year (2012-2013), and often into the first year of full operation (2013-2014). Key issues for them were to align themselves with their wider organisational structures – working out how best to fit with existing/emerging directorate structures and with existing councillor committee

structures – and to identify ways of saving money. Our data indicated that public health does appear to have been more strongly pushed onto the agenda of LAs, with health improvement a key priority.

PHE's priorities were similarly dominated by processes of establishment for some considerable time. Whilst PHE published 'health and wellbeing: an introduction to the directorate' (PHE 2013), which identified the key areas of public health they wished to focus on, public health practitioners interviewed at local level throughout 2014 were not clear about PHE's role, resources, or their relationships to LAs and others – particularly with regards to PHE's local centres. This chimes with findings from a survey of PHE's stakeholders conducted in December 2014 by Ipsos MORI, which found that two in five stakeholders felt that PHE did not have a good grasp of their own priorities. In addition, only half (51%) of LA respondents felt that PHE understood the priorities of their organisation (PHE/IpsosMORI 2015). The very recently published findings of Ipsos MORI's 2015/16 survey found that the proportion of LA respondents feeling that PHE understands the priorities of their organisation have further decreased, to just 31% (PHE/IpsosMORI 2016). The House of Commons Health Committee enquiry into PHE (2014) also raised a number of concerns, including: that the PHE Board had not yet established prioritized programmes of work which reflect the objectives of the organization (p.4); that PHE staff did not have the freedom to contradict Government policy; that PHE had not yet been able to provide a "fearless and independent national voice for public health in England" (p.4); and that PHE needed to do more to "oversee the development of the professional public health workforce and ensure that there is sufficient capacity across England" (p.4).

NHSE and CCGs, following their establishment, were quickly focused on the nationally prioritised task of health and social care integration. The Better Care Fund (formerly the integration transformation fund) was announced by the government in the June 2013 spending round. It represented the creation of local single pooled budgets to incentivise the NHS and local government to work more closely together to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The fund was not created from new or additional money, but was rather about spending existing budgets differently. The national conditions for its use were stringent, and plans had to be assembled very quickly, with insufficient time to engage properly with acute providers, whose buy-in was essential for the plans to work (Humphries 2014).

The Better Care Fund ensured that CCG and local council priorities (particularly for adult social services directorates) were dominated by the health and social care integration agenda. It was a critical part of the NHS two-year operational plans and the five-year strategic plans, as well as local government planning. With public health responsibilities and staff moving from the NHS to LAs, our data suggested that CCGs have become more distant/removed from the public health function.

Priorities between organisations at local level were strongly focused on alignment and integration – both to improve outcomes and to save money. Some areas were starting to go down the road of pooled resources and shared decision making. In other areas it was more like organisations were

informing each other, with HWBs being less about *making* decisions, than discussing decisions that had been made.

5.2.2 Developing strategies

NHSE and PHE, as new organisations, published strategy documents soon after they were established. Following the initial flurry of activity demanded by the Better Care Fund, a comprehensive strategy for the NHS was published in October 2014. This ‘Five Year Forward View’ set out how the NHS would have to change to help bring about a “radical upgrade in prevention and public health”.

However, as one NHSE senior manager explained, people are struggling with thinking through how to bring about those changes in a time of financial constraint:

“in a capacity limited system, which we truly have at the moment, then I think people are still going to be not living hand-to-mouth but having to deal with everyone in the waiting area before they can think about their strategy for tomorrow” (NHSE senior manager).

Strategic development across PHE was perhaps more complex as it was created from the bringing together of multiple former organisations, and resulted in large directorates for health protection, knowledge and information, health improvement and operations. Some of our national and regional level interviewees felt that PHE nationally struggled somewhat to get a hold on the health improvement agenda (although they were felt to be much clearer on health protection):

“The national PHE teams hadn’t really got going on any ‘strategic intent’ at an early stage - it took them about another year to lay out the five ambitions and there are now seven ambitions, many of which overlap with our [regional] priorities but they don’t entirely so” (PHE Regional Director)

PHE seemed to have some tensions to work through with regard to its organisational priorities. Sometimes these tensions related to how its services fitted with those provided by others in the system. A former PHE staff member commented that whilst PHE is supposed to be providing the evidence base, “*actually the evidence field is pretty crowded already with NICE and academia and so on*” and “*PHE doesn’t really have the capacity to be able to contribute terribly effectively to that field*”. Some of the tensions are associated with its relationship with the DH, which requires a cultural shift in the way the public health profession have been used to working. One PHE staff member explained that public health professionals are not used to behaving as civil servants:

“the inclination of somebody from the health service background, you know, it’s the first thing that civil servants will tell you: ‘if the minister says jump you say how high’, whereas, you know, we were always taught ‘somebody says jump you say why’”.

Some stakeholders had been left wondering how PHE can add value within the system:

“If it’s not going to be on the inside determining policy – and I don’t think it is – then I think it needs to be properly outside in order to be able to critique and be credible and I think that’s the difficulty that it will run into” (former PHE staff member).

There was tension too with regards to its relationship with the local delivery systems, and how strategies at each level could be aligned:

“there’s a mismatch between what we [PHE London] were interested in and what our boroughs were interested in and what the national team are interested in and vice versa” ... “they [PHE national level] may have big teams producing lots on one particular area but it’s not come up in any of our health and wellbeing strategies” (Senior manager, PHE London).

PHE have produced much information and many publications, but several interviewees at regional and local level felt they were missing guidance about how to respond – one respondent felt PHE were willing and enthusiastic but not terribly influential:

“They have a tendency to produce toolkits, evidence bases, documents which we’re not quite sure are needed and actually when they go out, have gone out in ways in which we don’t think maximise their impact” (DPH not within a case study site).

Locally, PHE centres are providing some good support, but resources are stretched very thin – a bit of a mismatch between what they can do in theory (influence local systems by developing good strong supportive relationships) and what they can do in practice (offer some support on an ad hoc basis and general oversight). One role that was carried out at regional level before the reforms related to lobbying and advocacy functions – that has fallen through a gap as PHE *“can’t really get into that space because it would be in conflict with their civil service role”* (former PHE staff member). LAs have a great deal more autonomy than PHE does, making them *“the most interesting place to do public health”* (DPH).

Key issues identified at local level tended to align reasonably closely with those that are highlighted at national level - obesity, mental health, dementia, and so on. However, LAs are more autonomous than PCTs were, and are more resistant to being told how to spend their money. In some local councils, they were starting to engage in discussions about how best to invest for improvements in public health – e.g. how to build health into planning etc. (see section 4). But this is a shift that wasn’t (necessarily) happening at national level, as a former PHE staff member explained:

“I think the people in PHE would like that to be the discussion that is being had but I feel that they are kind of shoved back towards a very behavioural low end of the Nuffield ladder-type approach in the way that they have to operate because of the political pressures and I don’t think that’s because that’s where the instincts of the people in Public Health England lie; I think it’s because they’re required to”.

He went on:

“There is a quite striking contrast I think between the broad upstream nature of some of the issues coming through the King’s Fund and British Academy recommendations and the rather behavioural disease-oriented thinking that seems to inform the Public Health England priorities, some of which is very, very arguable.”

5.2.3 Organising to deliver services

Again, the story of continued upheaval has impacted on the various elements of the public health systems and their ability to effectively organise to deliver services. There have been efforts and issues to deal with to organise both between and within elements of the delivery systems. One key issue appeared to be around the role of the NHS in public health delivery, and the role of public health professionals in influencing and informing the work of the NHS. Two different regional level PHE senior managers shared their thoughts on this:

“Our real issue ... is the extent to which we’re influencing mainstream NHS commissioning ... And that’s complicated because it’s partly NHS England but it’s actually the CCGs and we’ve got a patchy offer from local government into CCGs as part of their mandated services so that’s just being looked at the moment. We don’t think a lot of local governments are actually doing very much with the CCGs and it will get worse” (PHE regional manager 1).

“So we cannot achieve the five year forward review simply by providing advice into the NHS. Can’t do it. We have to be in the NHS and we have to find our friends in the NHS. You can’t really do that easily from outside, particularly when you’re a very small service being pulled in every direction” (PHE regional manager 2).

There are also some issues around the relative functions of different elements within the systems. In the reorganisations, some cracks have emerged; where cracks appear, things are in danger of falling down them. A senior regional level manager from NHSE talked about, as an example, the lack of workforce planning to be able to deliver bowel scope screening. This function (the delivery of bowel scope screening) was handed over to NHSE. However, our interviewee noted that there is no capacity in many of their units to be able to deliver what is required:

“Now it may well be that this is a particular programme and it’s a victim of appearing at this part of the transition and therefore it’s kind of fallen through the cracks but it’s a real problem in terms of having any staff to be able to deliver it and having it handed over and then PHE expecting us to deliver when we’ve got no-one to deliver it” (NHSE regional manager).

Another NHSE senior manager, at national level, talked about obesity as an example of where the commissioning and delivery systems have become much more complicated since the reforms:

“It’s quite... obviously quite a complex pathway but that was an example of how all of a sudden from having a situation where things were generally commissioned from a PCT base

for an entire obesity pathway, now you were talking about three different commissioning organisations and of the same pathway”.

Our case study work showed that these cracks were often reflected at local level too (see sections 4 and 6).

5.3 Cross-system co-ordination

The public health system emerging from the reforms is fragmented in terms of governance and leadership, accountability structures, and delivery mechanisms. Co-ordination across such a system (or systems) is difficult, though more important than ever, to achieve. In addition, due to the scale and impact of the reforms, many co-ordination mechanisms have had to be re-built or built from scratch. Informal coordination across the system appeared to have suffered from the upheaval created by the reforms – with new organisations being more inward looking as they worked to organise their internal affairs, and with staff movements, role changes and structural reorganisations.

Our data suggested that work was not always being coordinated very well at national level, with survey respondents saying they had little support at that level and the feeling expressed by interviewees that PHE need to shift their gaze more to a local level. However, there were signs that PHE were learning and improving and were working on having a business plan of what products and outputs were going to be produced and when, which would be negotiated with the PHE centres.

At regional level, it seems even harder to align strategies for public health. Informal co-ordination between public health staff at this level has been affected by the removal of strategic health authorities that provided regional forums as part of their regional public health function. Co-ordination at this level is now more complex, involving new emerging regional groups and networks (particularly as in site E), and involving PHE local centres and NHSE area teams. A PHE London manager explained that where strategic planning groups were being formed from multiple CCGs, there was *“almost no public health input because it’s difficult to find out who’s going to do it”*. Where bigger health economies, for instance, look at closing A&Es and reconfiguring the services, the same manager explained *“they struggle to get public health advice because they’re not operating at the borough level which is where the money and accountability goes”*. The issues were of capacity, and who was responsible. Because of real lack of capacity (*“we don’t even have the resources to respond to 32 boroughs’ public health teams”* – PHE London manager), they were having to work together to agree what the *shared* priorities were over a larger area, making the responses less locally nuanced. Some regional structures had staggered on despite the reforms (e.g. regional tobacco and alcohol offices), or had emerged through a desire to create a more joined up system.

A regional level manager from NHSE also pointed to the difficulties of working across a more fragmented system:

“what we don’t do I think very well as a system for example we don’t ever say, ‘Hmmm, thinking about obesity well, you know, kind of what are we doing to start people...’ you

know, 'how are we making sure the CCGs have got breast feeding strategies,' because that's what we would have had, you know, years ago and we'd start from there, wouldn't we, in terms of, you know, you start and you work your way through the system and you look at where are the interactions and I think probably unlike in the days where there was a PCT there isn't that one co-ordinating strategy that runs across all organisations. Or there may be and I'm just not aware of it but we would have to have that 32 times now, wouldn't we." ... "And all partners signed up 32 times to do various bits and pieces and it's just... I suppose that's... I suppose all I think is it's made it slightly more difficult" (NHSE regional manager, London).

And at local level, much of our data pointed to the difficulties of co-ordinating across a fragmented system. A manager in a CCG in site C commented:

"the fact that we've got commissioning being done by NHS England, by public health, by CCGs, by specialist commissioning – so that whole fragmentation, I think, has caused...well, obviously a lot of churn in the system and it's much harder to knit that back together".

She echoed what we heard from many interviewees in local areas when she said:

"You work with what you work with and we'll find a way to make it work, but it doesn't feel as joined up as it did before".

In one site in our ongoing research on CCG commissioning, concerns were raised about the re-tendering of a public health service to a provider outside of the CCG area. The CCG expressed their concern to the LA as GPs felt they should have been consulted given their knowledge of local services and highlighted the need to use the experience as a prompt to consider in more depth the CCG's relationships with LA commissioners. In the PRUComm research on CCG commissioning (McDermott et al 2015) CCGs commented on the way the changes had disrupted their relationships with public health: *"The main theme when discussing working with public health can be surmised in four words: where did they go?' Respondents frequently cited that there was very good contact and relationships with public health whilst they were at the PCT but these relationships have been severed with the move to local government. Public health is now largely but not wholly seen as more remote with much less contact and not linked to localities as they used to be."* (p102).

A key role for public health professionals at the local level was identified as being around cross-system influence, intelligence and co-ordination. Public health:

"plays an interesting role as a kind of glue in the whole system ... maybe that's partly almost because they have a little bit of a foot in both camps but it's also that they are able to take that, you know, that big picture view of what the needs are and what the pressures are" (Councillor, site A).

Respondents in one of the sites highlighted the role of public health team as leading and supporting *"... the system to deliver public health"* (DPH). Influencing the system was seen as a key role of the public health team. However, the disruption caused through reorganisation has meant that

continuity of relationships has been difficult in a system that has been thrown into such flux, with many people moving into different roles, organisations and geographical areas.

In one of our county sites, an elected member explained how recently, with public health being part of the council, and with the new emphasis on prevention and integration, some work they had begun several years previously had really started to take off:

“So we did some work about two years ago where we tried to look at primary and secondary prevention across the council, with children’s, adults’ and public health mainly, and to see if we could get a joint approach to that. We got a set of principles but public health and children’s and adults’ [services] don’t work always as closely as they could. We’ve expanded that this year and we’ve got a really exciting piece of work that we’ve been doing together with public health ... the relationship’s progressed to the thing where we’re now working across [the county] with the clinical commissioning groups, the district councils, public health, children’s, adults’, on sort of a merger piece ... That’s led by public health, supported by all the rest of us and we have a joint board and we’re going to look at can we actually figure out as a ... locality, is what we’re all investing in prevention, what difference that’s making and where the money actually needs to be redirected”

It was evident across all our sites that many meetings were taking place to bring the relevant people together, and to attempt to create some linkages between different elements within the system. We saw LA public health teams and CCGs learning how to work together, not as part of the same organisation, as they once were, but in separate organisations with their own organisational priorities (which are dominated by the need to cut spending). Whilst these organisations share the same goals in terms of health improvement, they have to work within their own, and the system’s financial constraints. Whilst this was not always a comfortable process, causing some ‘tussles’ over who ‘should’ be paying for what, the situation was prompting organisations to work together to think about how things might be done differently, as this CCG manager in site C explained:

“Every time public health make a cut, we can’t step into that. Now, we’re trying to work our way around it so we talk about where are we proposing to make cuts? What are the unintended consequences? How can we mitigate against this? How could we do this differently? Could we commission this together, instead of you doing that bit and us doing that bit? And we’re working our way through that but it’s harder than it was. It’s harder than it was”.

We saw in our case study areas that commissioners within public health teams were making efforts to communicate their commissioning plans with CCGs – in site A, the head of commissioning went on a ‘roadshow’ taking their commissioning intentions out to each of the CCGs. This represented part of the attempt to ‘align’ commissioning intentions. In this site, they were at the early stages of thinking about more co-ordinated processes of co-commissioning for health improvement services.

Public health staff demonstrated that their roles within the new system focused much more on making connections – across the council, and externally, linking in to other agendas (e.g.

sustainability), and identifying 'co-benefits' across different organisations and issues. In addition, elected members, who have historically had a role in helping to coordinate local action, have become more important as actors within the public health system.

However, many respondents referred to the complex local environment for public health, especially where the public health team spanned more than one council and where there were multiple providers. For example, a respondent working in a healthy schools partnership in site B commented:

“the other area is getting the partner support, now when I say partner that’s going to be LAs/NHS services, and for me that was going to be complicated because they operate differently across the [local councils], so there might be a dietetics team for example, working in one [council], but not in another, so I know I can get them to work with the schools around healthy eating policies. You’ll get different levels because of the different contracts with those [councils], so you’ll have different people on different contracts delivering certain services, you might have the police delivering on drugs, gangs and violence in one [council] etc, any of those partnerships I have to start bringing them in, then you start working with those that aren’t in LAs, so you might have e.g. the dietetics team, who are part of the NHS ...”

The complexity led sometimes to confusion and a lack of co-ordination. In site D, the NHS trust ran a programme for schools, but there was no consultation about it. There was a lack of strategic linking across programmes and it felt that there was a need for less of a silo approach and mentality. A local councillor was particularly critical of CCGs for not working in partnership:

“...the trust...they're running something in the school holidays with no discussion to public health or to anybody else...like they should be doing, they've done it off their own back, so it's a real dog's dinner, you know...” (Councillor, site D)

In site A, a public health officer explained her confusion when she read in a strategic report that a CCG were planning to create a central portal for health promotion services. These health promotion services were largely commissioned by the council, and the council had been having their own discussions about creating a central portal, but the public health team were unaware of the CCG's plans.

Whilst our research did not focus on collecting detailed data on regional or national level co-ordination mechanisms, we did get insights into co-ordination mechanisms within our case study areas. Local systems are seemingly difficult and complex to co-ordinate. The organisations have internal management systems that are largely incompatible with each other, and we identified issues with information sharing, for instance (see section 4). The external accountability of the system is complex, given the achievement of outcomes is dependent on organisations working together, but accountability for public health outcomes largely goes from the DPH, through PHE, to the DH.

The most important co-ordinating mechanism identified at a local level was the HWB. HWBs were established to provide co-ordination and strategy development in the local system. It was clear both from policy documents and from our research data, that HWBs have an important role to play in cross-system coordination. In our earlier interviews, participants usually talked about HWBs with a sense of optimism. HWBs were seen to play a key part in (potentially) pushing ahead system change, particularly around the integration agenda. Their position in the council, and their membership - often chaired by a senior councillor - was seen to give the HWB the opportunity to progress on the whole redesign of the system, taking the public with them as they went.

HWBs were expected to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate. They were described by the DH as *“sitting at the heart of local commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community”* (DH 2011c:7). In our 2014 survey (Jenkins et al 2015), respondents reported that the main benefit of the HWB was that it was ‘definitely’ instrumental in identifying main health and wellbeing priorities (61%, N=81), although as many as 63% of DsPH felt that the HWB was ‘not really’ making difficult decisions. In 2015, respondents still thought that being ‘instrumental in identifying the main health and wellbeing priorities’ and ‘strengthening relationships between commissioning organisations’ were the most effective aspects of HWBs (with 48% and 45%, N=65, respectively in these areas saying that HWBs were definitely having an effect), and 54% thought that HWBs were not really making difficult decisions. In the individual authorities where we could compare 2014 with 2015 the same overall pattern emerged, although there were individually changing views regarding whether their HWB was beginning to address the wider determinants of health, as nearly a half of the DsPH gave a different reply in 2015.

The relationships between county and district councils raised particular problems around co-ordination and how sub-county HWBs were organised. In both our county sites, due to the large number of district councils, not all could be represented on the county-level HWB. However, both had representative district councils on the board, and, as described in our previous report (Peckham et al 2015), there were local versions of HWBs in both counties. These were aligned with district council or CCG boundaries and involved public health representation, providing a framework for embedding county-based public health specialists in more localised activity. However, there was variation in how the local HWBs were functioning (discussed below). As the DPH in site A observed – *“I’m not sure we’ve quite got all of that sort of relationship stuff right”*.

The DPH is a statutory member of the HWB, but within our case study sites there were different expectations about how engaged HWBs actually were, or should be, with the wider public health agenda:

“We have a very strong focus on integration, Better Care Fund – all that side of things. I’m conscious sometimes of an element of criticism. Well I mean when I say criticism it’s probably a bit strong; there’s always a challenge to say, ‘Are you actually thinking enough about long term determinants and all the sort of public health agenda’ ...” (Councillor/Chair of county HWB).

Concern had been expressed that HWBs might be “talking shops” as they did not have statutory powers (HCLGC 2012, Humphries and Galea 2013). However, respondents in our case studies were generally positive about the role of HWBs, despite some feelings that these roles were still developing.

Our 2015 survey results confirmed that most DsPH (96%, N=69) and elected members leading on health (97%, N=36) were members of the HWB; this had not changed since 2014. Our survey asked if membership of the board had enabled DsPH to have greater influence and replies showed that in 2015 more DsPH felt that a seat on the HWB had enabled them to strategically influence work in the local health/social care community (83% N=66 in 2015, compared to 77% N=35 in 2014), more felt it had allowed them to influence decision-making in other organisations locally (74% in 2015, compared to 68%), and more felt able to influence decision-making in their own organisation, (74% in 2015, compared to 66%). This suggests that, despite mixed views on what the HWB was achieving, DsPH were continuing to gain influence through being a board member. Figures for elected members were slightly lower with 60-69% saying membership of the HWB allowed them to be influential in these areas.

In such a fragmented system, it was clear that HWBs could not always accommodate all the key people around the table. In site D, this councillor pointed to the absence of NHSE from their HWB and the problems arising from this:

“in the new structures, NHS England have a major role to play in the financing of primary care. ...Yet, it's only the CCGs that have tapped into the collective of the health and wellbeing board. NHS England isn't. And they think, or apparently...it's apparent to me they think they can operate outside of it. And we had an example only this year whereby, about a week after the CCGs had committed to the Better Care plan, NHS England reviewed some of the funding decisions about primary care and pulled a lot of money out of primary care. Well, completely the wrong timing, no warning, no consultation. Just letters written to practices saying, the funding you had last year is no longer available. When the whole primary care system just agreed to this major Better Care plan process”.

5.4 Summary

In terms of identifying priorities and developing strategies, whilst there has been frantic activity around the re-organisation of systems, structures and processes, which have had important knock-ons for role, relationships and functions, we have not necessarily seen any real shift in consequent priorities and strategies. Elements of the new system continue to negotiate relationships with each other in terms of public health delivery. There is a continuing dynamic introduced as public health services are decommissioned and re-commissioned by LAs. In addition the relationship between public health departments and CCGs remains unclear in many areas with concerns remaining about the range and type of support provided by public health to CCGs. System co-ordination also remains an area where roles and responsibilities are not clear. The aim was for LAs to become system leaders with HWBs providing leadership, co-ordination and system governance. Our findings suggest that

while LAs are developing their leadership role there is little evidence to suggest that HWBs are undertaking a system co-ordination role or prioritising public health issues. From our research it is also apparent that there is a mismatch between the rhetoric at policy level which emphasises the importance of prevention, and the reality which has seen cuts in public health funding and refusal by policy makers to take positive action on key potential 'system-level' levers for change favoured by much of the public health professional community (e.g. minimum unit pricing for alcohol and a sugar tax for sugar-sweetened beverages). Our data does suggest that the public health profession (now largely performing as civil servants within PHE and local councils) has lost some of its independence and authority in terms of being able to speak out on key issues where their views are at odds with LA or national government policies.

6 Obesity prevention and weight management – signs of a new approach?

This section of the report discusses the work of public health in relation to approaches being taken to tackle obesity following the move into local government. Obesity was chosen as a tracer issue to explore aspects of the move in greater depth (for example, commissioning of services) and in particular the extent to which there are ‘new ways of working’ in the LAs. Most of the findings relating to obesity come from the case study sites, with the survey contributing information only on changes in the commissioning of weight management services. We investigated what and how things have changed with regard to weight management and obesity approaches since public health moved into local government, and go on to highlight areas of challenge and opportunity in this regard. Given that the move of public health was seen as an opportunity to work in new ways and to enable a focus on the wider determinants of health at a local level (Gadsby et al 2014), we also explore public health engagement with LA planning and education departments on health related initiatives.

6.1 The changing nature of weight management services in local government

All of our study sites have adopted changes, to some extent, in their strategic approach to obesity and the delivery of services to tackle the issue. Throughout the period of our research, a large number of guidelines were produced which helped to reinforce obesity as a key priority, and to promote more consistent practice in this area, including: NICE public health guidance and advice LGB9 (May 2013), PH47 (Oct 13), PH53 (May 2014), PH54 (Sept 2014), CG189 (Nov 2014), NG7 (March 2015), QS94 (July 2015); and a joint report on commissioning obesity services (March 2014).

In addition, as discussed already in section 4, the new role played by elected members in public health decision making had prompted a fresh look at approaches taken. In our survey of elected members with the health portfolio in 2015, we asked what their authority’s main areas of activity were in regard to preventing obesity and improving weight management. Many councillors indicated that they were aiming to increase levels of exercise and sport generally, and had focused their efforts on children and schools. Elected members leading on public health also said they were working with planning to increase parks and open spaces and reduce fast food outlets near schools, and mentioned other schemes such as weight management and healthy eating, and running broader campaigns for lifestyle change.

6.1.1 Commissioning

The transfer of contracts to the LAs prompted significant reviews of weight management services, like other service areas across public health. In some cases, historical and current commissioning was being compared across different areas that had been brought together (e.g. where several PCT teams merged into one council). Services and contracts were often subject to a new type of, and more intense scrutiny as public health officers were asked to ‘prove’ to elected members that the budget was being spent to best effect. In several of our sites, these reviews raised important issues of gaps in provision (particularly for children and for tier 3 services), or of effectiveness, equity and value for money. As this public health lead (site C), explained:

“What we found on review, [was that]...they [weight management programmes] were really good if you were white, female, middle aged, middle class, that was the typical attendee at one of the sessions that we ran; so we weren’t getting to see people that didn’t look like that really...but overall it was difficult to establish that you were achieving value for money really, for the amount of money that was going into those programmes”.

A review of weight management services in site C found that costs ranged from £75 to £6000 for a successful weight loss intervention. This site decommissioned some key weight management service contracts soon after transferring to the LA.

Similarly, a review of services across site A found a large number of providers, delivering a plethora of services, with little evidence of effectiveness, such that practitioners on the ground were often confused about what services were available for whom. As a result of this and other service reviews, and with a focus on cost efficiencies, the public health team were embarking on a complete overhaul of their separate health improvement services to commission a new holistic model.

So a great deal of change has been observed in the commissioning of weight management services, both in our case study sites, and nationally. Our 2015 DPH survey (N=68) found that in the previous 12 months, 35% of respondents reported commissioning new weight management services, 22% reported decommissioning services and 16% reporting having made other changes to their weight management services. In comments, respondents reported wanting to shift away from ineffective schemes, to increase their focus on children, to use new providers, and to create a more integrated pathway. In four authorities, DsPH said that they had re-designed or commissioned new tier 2 and 3 services.

The fragmentation of commissioning responsibilities has already been highlighted in this report, and we saw this in particular for weight management/obesity services. PHE have also highlighted this in a recent review of tier 2 and 3 services, which noted that *“there is a lack of clarity for commissioning responsibility for tier 3 services” (2015:31)*. Despite the sharing of responsibilities across a range of organisations, we saw in our case study sites that LAs were taking a strong lead (and in some cases operating alone) in their review and development of obesity pathways.

In three of our sites, we saw a general shift in terms of commissioning healthy lifestyles services away from targeting individual elements of lifestyles in isolation, towards the commissioning of services on the basis of an integrated model that brings together weight management, smoking cessation, alcohol reduction and sexual health services, and so on. This was sometimes talked about in terms of a ‘whole council’ or holistic approach, but it didn’t always represent a shift in approach away from individual lifestyle change. In one of our sites, there was discussion about the development of a whole council approach which utilised both the LA and public health skill sets, to address a range of factors that influence obesity to ensure positive outcomes. The aim was to ensure that individuals and families are considered holistically and to maximise the chances of

behaviour change by shaping the environments in which they live – for instance, by taking positive measures to encourage active transport.

“You know it’s important to work across a whole systems approach, including the environment, and seeing how we can make people ready to change their behaviour”.
(Obesity Programme Manager, site B).

We saw some clear evidence of the impact of financial cuts on service reviews and commissioning decisions. In one site for example, there had been a significant reduction in services and one respondent remarked that they had seen a large reduction in the breadth and scope of weight management and physical activities services provided (especially for children) after public health had transferred into the LA. These concerns were also mooted by service providers in the same site, particularly from a community dietician service, over both the nutritional aspects of public health activities and the inability to meet service demand due to the lack of staff or resources to deliver programmes and initiatives. Funding was becoming a similar concern in site C with proposed cuts to a school based initiative focusing upon healthy weight. However, in site B, we saw evidence of additional investment in obesity prevention / weight management services, driven partly by the responsible cabinet member, who identified child obesity as a key public health priority in their council.

6.2 How have things changed?

6.2.1 Obesity tiers and pathway provision

Not all of our sites had obesity pathways for both adults and children. There were also gaps in service provision, particularly at the more expensive, clinically-led tier 3 level for obese individuals. This finding was consistent with a recent review of tier 2 and 3 services conducted by PHE (2015), which also found that some LAs were commissioning tier 3 services despite them being identified as a CCG responsibility. This was the case in two of our case study authorities. In site A, there was an expectation that CCGs would take responsibility for it in due course, in accordance with guidance. In site E, however, it was mentioned that this arrangement ensures smooth pathway provision between tiers by giving commissioners a holistic overview of the system. In our other case study sites, tier 3 provision continued to be an issue, owing to insufficient provision by the CCGs or lack of clarity as to whose responsibility it was to provide services. In site D there was no tier 3 provision at all, and it was believed that the CCGs did not see it as a priority. A dietician noted the problems this raised:

“I think we do have patients who would benefit from tier 3 and at times it’s difficult for us offering them the level of support they need”.

One of the overriding themes emerging from the interviews is the lack of, and gaps in, provision of services for children across the sites. What is available appears to be disparate and disconnected. For example, a clinical manager in one site discussed the paucity and fragmented provision of weight

management interventions for children. There were also no family interventions at the time of the interviews once children were identified as being overweight. Another respondent from the same site suggested that this situation was exacerbated by a lack of financial and human resources which meant that there was not enough capacity to deal with the scale of the obesity problem and the commensurate demand for services. The participant felt that they had been successful in raising the profile of childhood obesity and increasing the referral rates, but there was less capacity (4 practitioners) to see the amount of children that needed weight management services (around 25,000):

“So there’s not a lot out there really, because we know that...well, just in school age children, there’s probably about 45,000 primary school age children, just primary school age children and we know that about a third of those will be overweight, so that’s 15,000 just in those years. We know that about five per cent will be severely obese and unfortunately there’s not the services to pick a lot of those up. In fact, to pick up more than a few per cent of them”

A public health specialist in site A commented that most of the focus thus far has been on the adult pathway but there was also an acknowledgement of the difficulty in getting families engaged (a concern also voiced by a health worker in site E). Specifically, both sites noted that there was a lack of tier 3 services for children, (in site A, children with complex needs were attending a community-based family-centred weight management sessions that were not really geared to their needs). In particular, there appeared to be very little provision for older children and teenagers at the secondary school age/level.

The difficulties encountered, in respect of providing services in two tier authorities, was also referred to. For instance, in site A there were difficulties in clarifying an adult pathway because of the large number of districts and CCGs involved in the coordination of such a pathway. Also, historically the two halves of the county had commissioned differently. A public health specialist in site A noted that there was much uncertainty with CCGs and in relation to health commissioning:

“...there’s still a lot of changes, a lot of uncertainty around who’s going to do the commissioning and over what geographies they’re going to be operating.”

However, whilst the picture appears negative in most sites, site B has a 5 year programme focused upon children and healthy weight, which was given a fourfold increase in investment since 2014. They had recently developed a new family orientated healthy weight pathway which focused on childhood obesity. A public health commissioner commented that before the transfer to the LA it had to be clear what was preventive work, what was early intervention and what was treatment, with the CCGs arguing over financial allocations and responsibilities for provision with the outcome being that: *“...there’s never been...a joined up care pathway and there hasn’t been a really good focus on childhood obesity promotion”*.

6.2.2 Obesity, planning and active travel

Since the move of public health to LAs, our case study work showed that there has been a mixed and patchy level of involvement between public health, planning and transport. Capacity issues and a history of little prior joint working were factors suggested for the lack of engagement between planning, transport and public health, particularly with former PCTs and districts. However, with public health being in the LA, there was a general consensus that there was more opportunity for planning and transport to contribute to the health agenda and there has been some obesity focused engagement where there had been none previously. A transport manager in site C suggested that there was awareness on both sides and at a number of levels, of the common benefits for transport and public health in relation to progressing elements of the health agenda through various initiatives. Compared to the former PCTs, they discussed how it was not obvious when public health sat with the PCTs how agendas on planning and transport could be progressed and it was reliant on the PCTs showing an interest in transport and planning issues. A planning manager (site C) noted on collaboration with the former PCTs:

“The only contact we had is when they wanted to build new hospitals or doctor surgeries or things like that”.

However, this public health manager with a responsibility for obesity (site B) acknowledged the role planning could play:

“...so if you think we have the services that are provided by the council, there’s some things that are important but might have an indirect effect, like planning and housing, well we can do something with social planners, make play areas, if we are designing new buildings are we going to be putting in more with steps, rather than lifts”.

An environmental advisor based in planning (site B) felt that the planning department had a significant voice amongst the public health team in terms of ensuring that wider issues were discussed and focused upon - for example encouraging walking as part of an obesity prevention strategy. They felt able to showcase what the planning team could offer, rather than resorting back to discussions about hot food takeaways which had tended to be the focus:

“In some ways... [the move of public health into local authority] has enabled us to have a proper conversation about you know this is what we can offer, this is what planning could do, rather than just going back to the default hot food takeaway”.

In respect of fast food takeaways, one of the main activities mentioned centred on the production of SPDs to restrict fast food outlets. It was also notable that in two of the study sites (C and E), the production of the SPDs was driven by elected members rather than public health. Since the move of public health into the LA, the planning department in site C had requested the guidance of public health on producing an SPD in regard to the restriction of fast food outlets. The SPD emerged from councillors’ concerns not only about the health impact, but also about the quantity of takeaways, in addition to them usually only opening during evenings and the lack of opportunities for other business developments. Another aim was to prevent any further takeaways from opening.

In some places, public health had made a tangible difference in the funding of initiatives that contributed to the obesity agenda. For instance, in sites C and A, public health had invested alongside transport departments into the promotion of cycling. Similarly, there was very good joint working in site D in respect of the active travel agenda with some joint funding of programmes and transport utilising the public health evidence base to good effect.

However, joint working across planning was more difficult in our two-tier councils. Overall, there had been very little progress in site A to align public health and planning activities except at a strategic level, with districts not generally engaged. In site D planning engaged in a rapid health assessment of a large scale housing development in one district where there had historically been good joint working. However, in another district there was no engagement between planning and public health. Even in some of our unitary sites it was argued that public health did not seem to fully understand the planning role and tended to view planning in terms of restricting hot food takeaways instead of focusing upon how planning can contribute to the wider determinants of health. Core priorities of the individual planning and public health departments and a lack of capacity were seen as the major reasons for not progressing some weight management related initiatives in site C.

6.2.3 Obesity and working with schools

Healthy Schools Programmes

The national Healthy Schools programme (discontinued in 2010) was seen to be continuing in four out of five of our study sites in various forms. In site A, although the programme was not badged as 'healthy schools', the programme displayed a number of similarities in provision to other healthy schools programmes across our sites.

In our study sites, healthy schools-type programmes were being shaped around local priorities and needs, with school personnel being trained to support children in adopting healthier lifestyles and to signpost to other resources. Many interviewees talked about 'whole school approaches' or holistic and strategic approaches to health promotion in schools, and either commissioners or providers appeared to be working towards supporting this. In one of our sites, where there had been significant increased investment in childhood obesity prevention, the public health team had commissioned a healthy schools partnership to support and encourage schools to develop and deepen their focus on health and wellbeing. The partnership was an alliance of LA and health services, together with a range of other agencies that work with schools. It is important to note that such activity is not new, but within the new system there are signs of increased opportunities for joint working across public health, education and other sectors. In addition, it was believed that the increased investment in child obesity prevention was in part because of the move into local government:

"...well I would say they certainly have embraced this and made it a priority. Before, this would have been a historical investment from the NHS, and they have committed to increasing it four fold" (public health officer, site B).

The story on investment and funding was mixed, however, and two of our sites had received cuts to obesity prevention services in schools. There were also signs of a lack of ‘whole system’ commitment to child obesity prevention/treatment. A public health lead in one site noted that of the thousands of children classed as obese in the LA area, the child weight management programme only had between 175 to 190 referrals a year. Interviewees pointed to a lack of partnership working and information sharing with other school based healthy weight programmes in the site.

National Child Measurement Programme (NCMP)

LAs are asked to collect data on children's height and weight from all state maintained schools within their area. The data are submitted to the Health and Social Care Information Centre (HSCIC) and all of the returns are collated and validated centrally. Until March 2013, PCTs were responsible for the collection, holding and processing of NCMP data. However, LAs are now responsible for the collection of NCMP data, as one of the core mandatory services within their public health contract. PHE provides operational guidance to LAs and schools to explain how to undertake the exercise.

The value of NCMP data was mentioned by several interviewees, and in site A particularly, a NCMP steering group and a set of NCMP locality groups had been established to engage a wide set of partners in effectively utilising the data. Improvements both at national level – with regards to data management and operational guidance – and local level appeared to have occurred in recent years. Some discussion by interviewees reflected ongoing national discussion regarding the best way to inform parents of their child's measurements. A dietician we interviewed described the original NCMP letter to parents as “awful” and “embarrassing”. Some local sites made modifications to the letters. It was clear that feedback to parents should include information on what services/support are available for overweight children and their families.

We identified issues associated with fragmentation of service delivery, particularly with regards to managing time lines. In site C, a public health officer complained that the programme was very poorly implemented initially, with the NCMP letters taking months to reach parents. This had subsequently improved thanks to a new database with real time data. The management of data was also seen to be complicated by fragmentation, as this commissioner in another site noted:

“...but of course it's much more difficult for us now. The child health information service is commissioned by NHS England and data from the providers, child health data goes there – we can't access it directly”.

In one of our sites, a new on-line portal was launched to allow parents to access their child's NCMP data. By registering on-line, parents could view their child's measurements in a more accessible and convenient way, and access information and support for keeping their children healthy. In another of our sites, multi-organisation locality groups were using NCMP data to prioritise activities in certain schools and local areas identified as having high prevalence of childhood obesity.

Other school based initiatives

During the time of the research, within our case study sites, we saw a number of different initiatives, involving a variety of providers. Some of these initiatives were new, some were re-commissioned and some were continuations of former initiatives. Such initiatives often resonated with national campaigns, for instance, to develop more positive food cultures in schools. Several of our sites commissioned family-orientated courses to help people understand the importance of healthy food, and to help them to work together to create healthy family meals. In some cases, programmes incorporated physical activity elements. In another site, a programme was commissioned to train school staff to deliver healthy eating messages in the classroom and provide schools with food and nutrition resources. However, the context for working with schools appeared to be difficult, with interviewees in one site talking about ‘change fatigue’ within schools (particularly associated with the ending of national programmes) and other interviewees talking about the constant flux that schools were in, and the feeling that it was not productive for them to become engaged with health programmes or interventions.

From the provider perspective, one interviewee noted how difficult it was to work with schools, how dependent it was on relationships and a particular staff member taking a particular interest, and how it was usually the schools with the most problems that were hardest to engage. In one site, the main provider had put a large amount of effort into engaging with schools, but they complained that it was hard to demonstrate the impact of this to the commissioning LA. This provider interviewee argued that there did not appear to be any benefits to them being commissioned by the council, and that there did not seem to be any more involvement with, or from, the education department in the authority. It was clear that the education department was very small, and as such, was focused on issues of education standards and Ofsted.

6.3 Tackling Obesity - Opportunities and challenges for Public Health

6.3.1 Opportunities

The move to local government has opened up opportunities to work on wider determinants of health and obesity, and there was some optimism in this regard – *“So we’re better placed to work on the wider determinants of health than were there previously” (public health officer, site D)*. We saw much evidence of joint-working, and the need to engage at a wider level across the whole council was often recognised – indeed, as this report has highlighted, public health teams have placed a lot of emphasis on embedding themselves within the council and across the local system. There were signs that at least some of this engagement with others was new, or at least of a different quality.

In most of our sites there was much talk about the need to focus upon the wider determinants of health and adopt a holistic approach to obesity. This talk is entirely consistent with the policy aims embedded within the reform process. This was sometimes expressed in terms of developing a ‘system-wide strategy’ or a ‘whole council approach’. It should be noted, however, that such talk is not wholly new, is consistent with a national discourse around whole systems approaches, and remained largely at the rhetorical level. One unitary council encompassed within site area A had made further progress than others towards working across the system and thinking about what a

whole systems approach might look like, but it is clear that it is far from easy, and will take time to see any concrete changes in action.

We witnessed some opportunities around funding and resources, although these were by no means universal. Historically, in site D, weight management was considerably underfunded. A public health manager in site D observed that now they were in the LA they were able to commission programmes as required, because they now had the funding. They noted that this was because the former PCT priorities weren't always the priorities for public health:

"I would say that moving into a local authority has actually helped the cause of public health because I think when, say, you're looking at obesity within the PCT arena it was just one, you know, small thing that PCTs had to look at. Of course the emphasis within the PCT was very much about curative services as opposed to sort of like public health. So I think in a way it's easier to actually address things like obesity within a local authority".

Another of our sites (site B) witnessed a fourfold increase in funding for a 5 year healthy weight programme for children. They have invested much more in their whole school obesity programme and are piloting other innovative approaches to obesity prevention. The emphasis on childhood obesity as a key priority came largely from a councillor in this site.

There were also opportunities inherent in the processes of service reviews that came about following the move into councils. Several of our case study public health teams conducted a thorough 'stock-take', analysed existing services, and put time into thinking about how they might commission things differently, or indeed commission different services.

6.3.2 Challenges

Whilst it was generally felt that opportunities for improved joint working had opened up following the move into LAs, these opportunities were sometimes difficult to realise. It was clear that where opportunities were realised, this was as a result of dedicated commitment and hard work. The building of relationships took time, and this required sufficient capacity across the system. Overall, we witnessed a lack of joined-up working between public health teams and districts in two tier authorities, and between public health teams and potentially influential directorates such as planning.

In two tier councils with a large number of districts, the variation in terms of these district councils' engagement complicated the provision and co-ordination of services. In one of our case study areas for instance, district councils were sometimes providers and sometimes commissioners of weight management services in one half of the county, and very much uninvolved in the other half of the county. Difficulties with engaging a large number of districts, and therefore with strategic coordination across planning authorities was mooted as being a barrier to increased work on wider determinants of health, particularly in site A.

Joint working with transport departments appeared to be simpler, being at county level. A physical activity manager in one two-tier site commented that their team “*work quite well with the other departments and we’re doing even more of it now as well*”. “*We work very closely with highways and transport*”. However, even in transport, joint work was not inevitable across the sites.

Wider strategic coordination across a fragmented system was also seen to be a challenge. A deputy chief executive of a provider organisation highlighted that there was a lack of strategic coordination and joining up of service provision, which was seen as hampering any positive impacts on obesity:

“...one of the striking things about obesity, and child obesity...is the fact that there’s a huge amount of work going on, but it’s incredibly disparate and disconnected. And...my emphasis really, is to try and connect it all together, because there’s no lack of effort going into it, but effect is limited, I think. If we did a cost benefit, the amount of effort that’s going in, as to the benefit that it’s having, I think it would be very limited. I think we’re focusing our efforts and our energies in the scattered way that we don’t know where... there’s a whole raft of stuff that people are doing, that we have no idea whether it’s got any effect whatsoever.”

In another site, interviewees explained that there was no strategic joining up of schools-based programmes and no linkages with the recent ‘holistic’ service around weight management, smoking cessation, alcohol intervention etc. This non-public health manager explained their frustration around the lack of joining up:

“...we’ve tried very hard to state our case about what we do in terms of physical activity for our young people [to public health] and how much that it is a preventative model certainly and we’ve put forward suggested programmes that we could run through [our organisation]... but it’s just fallen on deaf ears would be my reading of it”.

This interviewee went on to note that they had no contact with other school based initiatives or the holistic service model. A non-public health manager working on the new holistic service noted that work with the ‘healthy schools’ initiative was “*...a bit hit and miss, to be honest...*”. A dietician noted that they only knew about the physical activity programme because of a (now disbanded) obesity partnership group (discussed previously) - “*We don’t really link up with them but I don’t know why. It’s not because I wouldn’t want to. It’s not because we’ve ever been offered and we’ve rejected it*”.

There was a prevailing concern about lack of and potential further reductions in staff capacity. For example, in one of our sites, there was a proposal for two full time dieticians to be reduced to a single part-time post and again in another of our sites they talked about there being not enough staff to meet demand.

Another challenge was voiced around the new emphasis on demonstrable outcomes. Two managers at a provider organisation in site A explained that the council were now more focused on the immediate impact on body mass index (BMI), so they, as providers, were tending to focus on delivering the targeted programmes (i.e. moving downstream rather than upstream). They argued that if services were commissioned with very specific targets (e.g. a percentage amount of BMI

reduction), then there were only going to be clinical-type services commissioned. There is an ongoing dilemma around how to measure effectiveness of universal provision. There is now a much stronger focus on outcomes, but it was argued that this raised problems around how to measure the 'softer' but essential foundation work.

6.4 Summary

Within all sites there was reference by some of those interviewed to the need to work towards a more holistic approach to obesity services with recognition of the need to tackle the wider determinants of health. However, this was not a universally held view with some sites demonstrating tensions between a public health "professional" perspective and a lay elected member view. There was evidence though that some of our sites were developing (or at least talking about) a 'whole council' or 'system-wide' strategic approach. This reflects the emphasis in national policy documents. However, gaps in pathway and tier provision, further funding cuts and a lack of partnership working in some areas, (either through programme provision, organisations or district councils), were hampering this approach. A feature in some sites was the disparity in the ethos, culture and provision and the subsequent impact on obesity services. What was clear was that having councillor and senior officer support (as in sites B and D), or not, could have a significant impact in terms of programmes being protected or commissioned, and we noted in our previous report (Peckham et al, 2015), how the new system gave rise to the potentially huge role a leader/chief executive could play in terms of determining the importance and focus of public health goals and activities.

These challenges highlighted for public health and tackling obesity are taking place in, (as our previous reports and interviewee accounts have noted), a new system which is highly fragmented which makes the provision and coordination of services all the more difficult. However, there is evidence that actors are beginning to shape services differently. We saw such an approach with the 'bottom up' policy context of the healthy schools programme in site C, and the utilisation of public health data and evidence by planning departments in most study sites, to coordinate service provision and for use in the production of SPDs. Conversely, with such restrictions on funding, it has been noted by some respondents that pooled budgets, integrating service provision, and adopting a more holistic approach will become the norm, as a transport manager noted, the days of working "in glorious isolation" are over. Certainly our national surveys indicated that broader and more integrated approaches were being taken in commissioning weight management services. Either way, strategically or through necessity, obesity provision in local government has and will continue to evolve as changes across the system seem to gravitate towards the development of locally determined and contextually sensitive approaches to public health and the range of activities developed for health improvement.

7. Discussion and conclusion

7.1 Policy goals of public health reorganisation

Prior to the reforms in 2013, the public health system was felt to be lacking synergy and suffering from inefficiencies due to overlapping responsibilities. A key objective of government policy, therefore, was to address the perceived fragmentation (DH 2012b). A number of changes were made to the structures and organisation of the public health function in order to:

- increase the emphasis on public health and disease prevention;
- create a more joined-up system with clearer leadership; and
- have a greater impact on the wider determinants of health at local level.

The health reforms were just a part of the wide-ranging series of policy reforms implemented by the Coalition Government and affecting all major departments. It is useful to acknowledge the set of principles that underpin this entire tranche of reforms. Briefly, these include (Revolving Doors Agency 2010):

- *Big Society*. This is about “putting more power and opportunity into people’s hands”. It is posited as an alternative to ‘Big Government’, and it emphasises personal, professional, civic and corporate responsibility (Cabinet Office 2010b).
- *Localism*. Localism focuses on the decentralisation of power away from central government towards local communities and individuals. It is about giving people as much power as possible in decision making and planning decisions. Localism is a key part of Big Society – giving people more control over decisions that affect them, and in return expecting people to take responsibility for improvements locally. The Coalition Government’s view was that “*the time has come to disperse power more widely in Britain today*” (Cabinet Office 2010a:7).
- *Freedom*. Along with fairness and responsibility, freedom is one of the three key principles of the Coalition Government, focusing on protecting civil liberties, repealing unnecessary laws, and cutting restrictive red tape (Cabinet Office 2010a).
- *Fairness*. The emphasis is on fairness rather than equality, and it is seen as something that cannot be achieved through centralised targets. Rather, families, charities, religious movements and co-operatives are seen to have a key role in helping to reduce the unfairness of poverty and deprivation and helping the most vulnerable in society.
- *Responsibility* – Government responsibility with public finances, personal responsibility for individual actions, and social responsibility towards each other. There is a strong focus on social and personal responsibility, in contrast to Labour’s more limited focus on state responsibility. Again, this is central to the notion of a ‘big society’.

We have seen in our research how these principles are embedded within the policies and implementation plans associated with health and social care reforms. They are reflected in the set of values identified by NHSE, which include ‘offering leadership and direction’, and ‘making patients, clinicians and carers central to decision making’. They are also reflected in PHE’s values, which claim a ‘culture of subsidiarity, focused on support for local accountability and action’ and emphasise its role as ‘advocate’ for public health.

The HSCA12 embodied the commitment to decentralisation set out in the Localism Act 2011.

“The Government believes that many of the wider determinants of health (for example, housing, economic development, transport) can be more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations.’ (DH, 2012d, p1)”

Localism was frequently used as a justification for the increased role of LAs in public health delivery, typically by spokespersons from the Government, DH or LAs. For example, Anna Soubry (then Parliamentary Under Secretary of State for Health) emphasised the central importance of localism to the reforms: *“... at the end of the day, we are all about localism and letting health and wellbeing boards determine their own composition and work, based on their own strategic needs assessment of their area.”* (Evidence to House of Commons Communities and Local Government Committee 21/1/2013).

In examining how the public health reforms have played out in practice however, we have seen that LAs clearly vary in their political persuasion; local politics, history and individual personalities will lend particular values and principles to these organisations, which may be in conflict with central government.

Putting LAs in charge of driving health improvement was central to developing a new approach to improving health and coordinating local efforts to protect and improve the public’s health. The transfer of public health activities into local government sought to build on the developing role of LAs in shaping local places to create healthier environments through spatial planning and local initiatives to improve health and wellbeing. This is in part due to the discretionary duty of LAs for *“...promoting or improving the social and environmental well-being of their area...”* (8) under the Local Government Act 2000. The move was not about recreating a pre-1974 landscape, when public health previously resided in local government (Gorsky 2014). Rather, it acknowledged the fact that local government had taken on a much wider role working with a range of partners to ensure that public health could have a significant impact on *“...the ‘broader determinants of health – people’s local environment, housing, transport, employment, and their social interactions – [which] can be significantly influenced by how local authorities deliver their core roles and functions”* (Buck and Gregory, 2013:3). The key role of public health in promoting economic, social and environmental wellbeing in local communities was considered a natural fit with this expanded portfolio of local government (DH, 2011b). The government set a number of policy goals in the White Paper (DH 2010) and in other policy guidance (See table 1, section 1.3). In table 7 below, we identify a set of key policy assumptions that relate to different aspects affecting the structure and functioning of the public health system.

The Government hoped for strong local political leadership and better integration between health, social care and public health, leading to a community-wide approach to protecting and promoting health and wellbeing. It was anticipated that the public health function would provide new opportunities and efforts to tackle the wider determinants of health at local level, as well as tackling

the individual and behavioural determinants. The Government envisaged that the DPH and the HWB would have key strategic leadership and co-ordinating roles to play in the new system. The HSCA12 gave LAs a statutory duty to create HWBs which were intended as forums where key leaders from the health and care system would work together *“to understand their local community’s needs, agree priorities and encourage commissioners to work in a more joined up way.”* (DH 2012c).

Table 7: Key government policy objectives

Leadership and governance	<ul style="list-style-type: none"> • LA and DPH = strategic public health leaders for their local population. • Elected members in councils to have leadership role in improving public health and reducing health inequalities. • Greater democratic accountability. • PHE to take national lead on public health – they will support, influence and monitor local provision, but the intention is that they have a ‘hands off’ relationship with local system design. • HWBs to provide overall strategic direction for improving wellbeing at local level.
Structural capacity	<ul style="list-style-type: none"> • New ring-fenced public health budget for LAs. • PHE established as single national public health body.
Outcomes and Goals	<ul style="list-style-type: none"> • Organisations held to account for achieving outcomes through the outcomes framework. • Greater uniformity of services across England due to identification of six standard functions that LAs must provide.
Values and principles	<ul style="list-style-type: none"> • Increased localism – emphasis on local solutions, decision-making and local democracy. • Further integration of services will lead to increased sustainability of services and to improvement in health and wellbeing outcomes. • Emphasis on shared responsibilities.
Population	<ul style="list-style-type: none"> • Local people involved in the preparation of their JSNA and JHWS through statutory duties.
Context	<ul style="list-style-type: none"> • Public health responsibilities vested in all county and unitary authorities. • Duty on HWBs to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population. • Promotion of competition. • Emphasis on efficiency savings.
Public health practice	<ul style="list-style-type: none"> • Local government has a new set of duties to protect and improve local public health. • LAs have new powers both to commission and to provide public health services.

Our findings suggest that achieving these policy objectives has been more difficult than anticipated. While the government’s proposals for public health were generally welcomed by both public health professionals and local government, many stakeholders and commentators raised concerns. The

recent announcement of continuing public health budget cuts has heightened concerns about the ability of LAs to deliver public health services – particularly in relation to developing the health improvement agenda and emphasis on prevention set out in Government policy and the NHSE Five Year Forward View (NHSE 2014). The key opportunities and challenges, as seen by these stakeholder and commentators, were summarised in table 2, section 1.4 of this report. We now reconsider those opportunities and challenges in light of our research findings. The focus of this project was on the development of the new organisational arrangements for public health in England and the impact this has had on governance and how public health is commissioned at a local level. The following section therefore summarises our research findings relating to these aspects of the Government’s objectives and our key research questions, focusing on the question ‘what has changed?’ in relation to issues of leadership and governance, structural capacity and outcomes and goals. The remaining key policy objectives also related to some aspects of our research and were explored where relevant and our key findings related to these other objectives are discussed in relation to what has changed.

7.2 Key findings – reconsidering the opportunities and challenges for capacity strengthening

7.2.1 Leadership and governance

There were opportunities associated with LAs being stronger leaders of local public health systems. Our research identified many opportunities for cross-directorate working, although it is unclear how different or new these opportunities were, given that there was considerable joint working happening prior to the reforms – although joint working with planning and transportation was less prevalent. We found that leadership for public health at local level had become more dispersed. The new system gives rise to the potentially huge role a senior councillor or chief executive can play in terms of determining the importance and focus of public health goals and activities. The DPH role has shifted from a key decision making role, to a more advisory one.

We found that councillors were playing a key role in holding public health to account. Councillors were often more demanding with regards to value for money and the demonstration of outcomes, although there was sometimes tension around how performance is measured for more complex public health interventions. There were also opportunities for the council to look more strategically at what they were getting for their investments in broader terms, rather than just focusing on specific service objectives/outcomes. There was some evidence of refocusing taking place, for example, with health trainers taking on a broader remit. It was felt that the new democratic context provided greater credibility for public health activity. There were concerns about councillor involvement and the visibility of public health compared to other services – for instance, councillors are likely to get lobbied more on visible services to the wider community (e.g. libraries, rather than sexual health clinics). It was recognised that working in a democratic environment is different to working within the NHS. However, public health specialists reported feeling accountable to multiple constituencies - the local population, the DPH, councillors, CCGs, etc. The situation appeared considerably more complex than before, with a fragmenting of governance. For example, there was

reference to fracturing between health improvement in LAs and more clinical ‘health services’ public health activity.

With regards to accountability, we found some differences in the line management structures and the relationships between the DPH and councillors in the different councils. All councils seemed to have some form of open channel between public health consultants/DPH and councillors, but there were differences in how line management was perceived and undertaken. Other public health staff had found difficulties in being held to account as commissioners, where councillors demanded detail about activities, services and outcomes. This suggested an increased demand for more detailed knowledge by councillors since gaining this responsibility, perhaps related to their accountability to the public. We found evidence to suggest that councillors were holding public health officers to account, but there was no clear pattern of where or how this happened within governance structures.

The sense of councils being accountable to the DsPH was less evident in our research. Whilst DsPH felt that it was their responsibility to act independently and bring public health issues to the attention of the council, there were clear difficulties in balancing this with their corporate accountabilities, and their need to ‘tow the line’ of the council. The influence of politics was stronger in some areas than others. In addition, whilst most DsPH reported having good access to councillors, they were not all a core/formal member of the council’s senior management team. Our research suggested that on the whole, DsPH felt they have less freedom and autonomy to make decisions than prior to the reforms. However, this did depend on a wide range of local contextual factors.

There was some concern about the advice and influence of public health over the NHS waning, with the relocation of public health staff being moved outside of the NHS. Our research found that relationships between public health officers in LAs and CCGs on the whole tended to be good. A number of key features and structures of governance aided these good relationships, such as key people attending each other’s meetings (for example, the DPH being on the CCG board and invited to their executive), and good joint working between the CCG and public health on various programmes (e.g. NHS Health Checks), joint commissioning and other initiatives (e.g. Better Care Fund). Relationships were threatened, however, by lack of capacity – particularly where shrinking public health teams were spread across multiple CCGs.

Relationships with CCGs were not without their difficulties, and opportunities to work together were missed. There was a sense among both public health officers and CCGs that influence of public health had diminished since its move from PCTs. Remaining concerns included confusion or disputes about funding allocations/funding streams; concerns around engagement on a variety of issues (e.g. long term conditions, relationships with GPs, the linkages between obesity tiers, engagement on the prevention agenda); CCGs feeling decisions were less informed by public health than previously; and CCGs feeling generally disconnected from HWBs.

The HWB is seen as crucial in ensuring local governance and stewardship (Coleman et al forthcoming). It was envisaged that HWBs would play a role in bringing together a fragmented

system and dispersed leadership, but our findings show the Boards to be still developing, with national imposition of new responsibilities, local variations and the establishment of working relationships and appropriate agendas being challenging. There is an ongoing struggle between local agendas (e.g. tackling inequalities) and a central government push (e.g. integration) where HWBs can only be a part of the solution, suggesting they may be best focusing on their local system oversight and co-ordination role.

Whilst HWBs were seen in theory as having a role in ‘holding public health activity to account’, they did not in practice have any inherent power to fulfil this role; it was also unclear how this might work. Our findings suggested that HWBs have dual roles of providing strategic leadership and building better relationships, whilst at the same time applying pressure and scrutiny where appropriate. These roles may be uneasy bedfellows. Within the HWBs in our case study areas, little attention was paid to public health compared to other key health issues, such as health and social care integration and the Better Care Fund. These latter areas are more dominated by national policy and imperatives.

The establishment of a new and centralised agency – PHE - at ‘arms-length’ from government was associated with a number of anticipated opportunities, particularly around bringing about greater strategic co-ordination at national level, bringing the evidence base together, and creating an ‘authoritative voice’ on all public health issues. Our research found that it took PHE a long time to get established, as it focused initially on its own internal operations, rather than on external relationships. Others within the system – particularly LAs – found it difficult sometimes to relate to PHE, and did not always see where they could add value. The relationship between key national system leaders – PHE, DH and NHSE – were not always easy, and were sometimes distinctly problematic. At local level, there was a mixed picture, with positive views regarding the support for health protection, but rather less positive views regarding data and intelligence. There were clearly opportunities yet to be realised in improving co-ordination across the system and in being an authoritative voice on all public health issues.

Our findings, alongside those of others (see for example Mansfield 2013, Willmott et al 2015), highlight the fragmentation of the new system, and the continued state of change as structures and processes evolve, and as roles and relationships develop. This is occurring in the context of wider change, as LAs (and others) continue to adapt to deal with financial pressures. Important challenges have been highlighted relating to inadequacies of the system design, particularly with regards to lack of clarity of roles and purpose, and fragmentation of responsibilities.

7.2.2 Structural capacity

It was anticipated that the reforms might bring about new opportunities for shared intelligence within local government. Our research suggested that while the opportunities for utilising public health data were still under-realised, there were signs that a wider range of LA directorates were starting to engage with public health intelligence. Advice and support was given by public health teams to other LA officers and external partners on using public health data. We evidenced

examples (for instance in education and planning) of where public health data was used to help decision-making, though it was clear that there was more potential for this to be developed.

We also found some evidence of public health and adult social care sharing data and information – adult social care often had ‘soft’ information that could be combined with the ‘hard’ quantitative data of public health. Councillors were also keen to combine their informal knowledge and ‘soft intelligence’ with public health data, which provided local “granular knowledge”.

The upheaval of system reform had inevitable consequences for data and intelligence however. Public health officers reportedly lost access to some data following the transition. One site stated they no longer have ‘medical’ data such as number of immunisations or screening uptakes, due to the fragmentation of the new system. In addition, some intelligence was lost within the organisational churn, as staff moved on and networks disbanded. There was some evidence that the loss of the regional structure had negatively impacted on structural capacity.

Whilst we found evidence that the new systems and structures provided some opportunities for creativity in combining public health and council functions, this was in the early stages and by no means universal. It was not possible to gauge the extent to which these new opportunities were a consequence of the system reforms. Indeed, many joint initiatives described by research participants had been initiated prior to the reforms, although it is possible that their progress may have been hastened once the different teams concerned were placed within the same organisation. We saw that public health teams had worked hard, with some degree of success, to embed themselves across their LAs. However, the process of settling in was not easy; public health officers found LA processes complex and rigid compared to those of the NHS, and found difficulties in adapting to the new organisational culture. Even those who worked in joint posts prior to the reforms admitted a lack of understanding of the differences between local authorities and the NHS, and of LA structures and ways of working. This was further complicated where public health teams were working across multiple authorities, either as a shared service, or within two-tier counties.

Whilst it was expected that collaboration across local systems would improve, particularly through the HWBs, our research found that processes of joint working were hindered by the ‘messiness’ of the transition period, and in particular by the lack of clarity over responsibilities and funding allocations. The context of financial austerity in local government and recent additional public health cuts also have not facilitated joint working and have, in some cases, led to suspicion between organisations about potential budget ‘raids’. Conversely, in some areas, the reduced/limited budgets have forced different approaches to be examined, which can be fruitful.

Human resources capacity faced challenges and changes as a result of the reforms. We found widespread recruitment and retention problems within the public health workforce, and continued concern amongst some participants regarding the fragmentation of the profession (with medical public health personnel choosing not to work for LAs), the reduced desirability of the profession amongst new recruits, salary issues, and the lack of opportunities for training and career progression. Some public health teams were significantly understaffed. Posts that were unfilled were sometimes swept away in subsequent reorganisations. Other public health teams maintained

similar staff numbers, but changed the nature of their staffing - for instance, replacing qualified public health professionals with commissioning or business planning experts. Respondents also discussed the impact of the reduction of key personnel during the transition period to local government and the impact in terms of the loss of knowledge and skills and 'corporate memory' in public health teams and the wider health community.

Within the new system, we saw fiscal resources being strengthened in some cases, and weakened in others. The ring-fenced budget for public health was found to have offered some financial security for the public health function, and gave DsPH the opportunity to think more strategically about how best to spend that allocation, rather than having to fight for allocations out of an NHS funding pot. However, there were plenty of opportunities for LAs to test the boundaries of the ring-fence, and public health teams in some cases had to strongly defend their budget. Within LAs, there appeared to be a stronger emphasis on value for money, and the transition presented a good opportunity to scrutinise contracts with a view to making gains in efficiency and cost effectiveness. We found that many services were being decommissioned or commissioned in different ways following these service reviews. Budgets were moving in some cases, as new services came under the public health budget, as budgets were pooled, and as public health made financial investments into other departments. In one of our case study sites, we also saw a significant increase in financial investment in childhood obesity prevention, largely pushed by the passion of the elected member and her fellow councillors. However, the overall picture was one of having to deal with reduced budgets, and we saw evidence of public health officer posts being cut, and services being decommissioned or reduced as a result. Since many public health services were still being provided by NHS providers, these changes in commissioning were impacting on local systems more broadly, with local NHS bodies receiving less income as a result of reduced LA budgets.

7.2.3 Outcomes and goals

Whilst the public health outcomes framework was meant to help shift the focus of commissioners onto outcomes, and act as tool to both guide and assess the work of local public health systems, we found very little attention was being paid to the framework in our case study sites. There was little evidence to suggest that the framework was being used by local health systems to either guide activity or assess outcomes. Rather, local priorities and locally determined outcomes appeared to dominate. It did appear from our findings that within LAs, there was a stronger focus on outcomes rather than outputs or processes. In some cases, and particularly for complex public health interventions, this was a challenge for public health officers and provider organisations to deal with, since the long and convoluted paths towards achieving, for instance, a reduction in obesity rates, was difficult for some councillors to understand. Although it was hoped that the reforms would reduce inefficiencies through creating synergies, we found evidence of duplication of activities, confusion over roles/responsibilities, and gaps in services, principally due to the increased fragmentation within the system, and the upheaval caused by the reforms.

It was feared by some commentators prior to the HSCA2012 being passed, that the reforms would lead to the persistence and potential widening of health inequalities, and a worsening of indicators around non-communicable diseases and 'lifestyle' issues. Our research suggested that there is a

(possibly increased) potential for inequalities between local areas to widen, since local areas differ with regards to the scale and impact of the budget cuts. For instance, research for the Joseph Rowntree Foundation (Hastings et al 2016), found that the most deprived upper-tier and unitary authorities saw cuts of more than £220 per head compared with under £40 per head for the least deprived. They also found social care spending had fallen in real terms in the most deprived communities by 14% or £65 per head. Conversely, it had risen in real terms in the least deprived communities by 8% or £28 per head. It appeared from our findings as though the services that are likely to be cut first are those that focus on preventing lifestyle-related illness – not because LAs do not care about these priorities, but because other financial pressures are greater, and/or other services are mandated. Within areas, the scaling back of services, and the high cost of achieving public health outcomes amongst hard-to-reach groups (who are often those with the worst health), might also lead to widening inequalities within local areas too.

7.3 Key findings - What has changed?

The move of public health into LAs has been set against the context of severe financial cuts imposed by government on LAs, and wider civil society, arguably in response to the global financial crisis in 2008 (De Vogli and Owusu 2015; Lowndes, 2013). Government financial support for LAs has been cut by over one-third (Centre for Local Economic Strategies 2014:4) which has impacted substantially on not just local government activities but also on their organisation and structure.

Public health teams in LAs have faced profound 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 needed to acquire new skills, and needed to seek new ‘allies’ to thrive in the new environment. In a fragmented system, strong relationships between these organisations are important. Strong relationships might depend upon clarity of roles, time to develop, protect and strengthen interpersonal relationships, a reasonable amount of stability (e.g. in the way of staff turnover, role redistribution, etc.), shared interests/agendas, and good communication/networks (Hunter and Perkins 2012, 2014).

Our research aimed to address five key questions about the reforms introduced by the HSCA 2012 in April 2013. These focused on structural arrangements of the public health function, decision making processes, the relationship between PHE and LAs, local relationships between LAs, CCGs and other agencies and the extent to which LAs were developing new ways of working. The following sections summarise our main findings in relation to these five key areas of enquiry.

7.3.1 How is public health ‘organised’ within the new system?

The findings from this research clearly show that the organisational arrangements for public health in LAs are complex, and still evolving. In two-tier areas, the important role of district councils is recognised but has yet to be fully developed. There are a range of organisational arrangements between authorities including joint appointment of DsPH, shared public health teams, formal inter-

authority collaborations and agency arrangements where one LA acted on behalf of another. These are not all discrete developments with some authorities displaying a number of different relationships. In addition to these inter-authority relationships, there are a range of differing relationships with CCGs, service providers and regional and national public health and NHS agencies.

We found considerable variation in the organisational arrangements for public health within LAs and identified a wide variety of organisational arrangements that included:

- Shared public health functions across two or more LAs sometimes with a single coordinated team and in others with a shared DPH but separate LA public health teams.
- Agency arrangements between authorities for the provision of public health functions.
- LAs with a public health directorate.
- LAs with public health as part of another directorate (eg Social care, community and housing).
- LAs with dispersed public health teams.

Despite the turbulence of the reforms, both public health leaders and elected members have remained positive about the way public health teams had transferred and become embedded in LAs. However, the organisational arrangements for public health remained varied, with the majority (52%) being within a larger directorate, such as adult services, and some remaining as a distinct public health directorate (26%)⁹. Also, even after two years there remained substantial organisational turbulence with continued reorganisation; the results of our 2015 survey of DsPH (September 2015) found that nearly half of the respondents reported that they expected further reorganisation of public health teams within the next year.

There was a variety of managerial arrangements and reporting processes within LAs. Our evidence suggested that where public health is not organised as a separate directorate, there might be a more immediate chance to be embedded into local government. However, where a distinct public health directorate is formed, public health professionals might have a greater degree of autonomy, and the DPH usually had a direct reporting line to the chief executive facilitating working across directorates. Access and direct reporting to the chief executive and elected members were seen as important in promoting public health. We found good evidence of close working between elected members and public health teams in our case studies. However, not all public health teams and DsPH have access to key executive decision-making groups at senior director level in LAs. This was important in order to promote a public health approach within LAs.

At the local level, there appeared to be stronger managerial accountability and scrutiny, led by elected members (influenced by their politics, ideology and granular knowledge). This is shining a new light on public health activity, and is bringing an important window of opportunity for change – we found evidence of historical commissioning decisions being challenged, new questions being

⁹ Data from 2015 survey but similar to 2014 survey

posed, new suggestions being made, and ‘permissions’ being granted to *think differently*. This is simultaneously liberating – providing opportunities for change - and challenging – particularly adapting to new cultural and organisational norms - for public health professionals.

7.3.2 *Where, how and by whom are formal decisions made about public health needs, priorities and strategies?*

We observed a number of changes to the way that public health priorities and strategies were being developed at local level. The greater involvement of elected members in the making of decisions had made a difference to decision-making. There was more emphasis on the use of “soft intelligence” drawn from member’s experience of their local wards. In addition, ideology in terms of perspectives on the function of public health and the key determinants of health of individual members or controlling political party were important. We found evidence that priorities on health were also driven by non-health issues – for example anti-social behaviour in relation to a focus on drugs and alcohol.

Strategic planning on public health has changed with councils taking a broader perspective of how public health issues should be tackled. In addition, we found that moving into local government had led to more service reviews, with an increased application of “best value” approaches. This arose not just from a change in culture between the NHS and local government but also the move was seen as an opportunity to examine how an identified public health budget could best be used.

The approaches to prioritisation and strategy development, however, are varied, and the degree of elected member involvement is mixed. Our surveys suggested that between 2014 and 2015 elected members increasingly wanted to see changes in the way their authority goes about identifying local needs, priorities and strategies.

7.3.3 *What influence does PHE have on local public health decision making?*

Respondents in our case study sites referred to the complexity of arrangements for commissioning and the lack of clarity of roles. However, PHE’s health protection and information roles were seen as valuable. Research participants at a local level and those at regional levels thought that PHE’s role was slow to develop, referring to its complex organisational arrangements. Further re-organisation had not helped. There was a degree of uncertainty about roles and responsibilities for different elements of public health activity – this also included the relationship between LAs, PHE and the NHS. In case studies, participants referred to the fragmented nature of both commissioning and provision responsibilities. Our surveys found that while PHE’s expertise in health protection was acknowledged and relationships between LAs and their PHE local centre were generally good, PHE support in terms of leadership and public health intelligence often fell short of what LAs were expecting. PHE have also carried out research on the views of its stakeholders which showed that those in local authorities tended to be less satisfied with PHE than in previous surveys with LAs feeling that PHE did not understand LA priorities and LAs having less contact with PHE than in previous years (PHE/Ipsos 2016:7).

7.3.4 *What is the nature of relationships between LAs and CCGs, and between LAs and other external organisations?*

Our findings suggested that insufficient attention was paid, when designing the new public health system, to the important public health functions of district councils. District Councils undertake a variety of public health related activities beyond those resulting from the 1984 Public Health Act including for example, leisure, housing, licensing, and planning (District Councils Network 2014). Working out this relationship (between district councils and county-based public health teams) is crucial and appeared from our research to be developing differently in different areas. In some areas, district councils were seizing the initiative and taking a key and active part in public health leadership. Elected members here, like their counterparts in the upper-tier authority, were challenging public health professionals, and seeking to influence them, as well as wanting to draw on their professional skills. Public health professionals, in their turn, were recognising the potential advantages to be had in engaging with this tier – despite the investment costs. In our two county case study sites, we saw how district-level HWBs were developed, and in some cases with a greater focus for public health discussion and action than the upper-tier boards.

The shift of public health teams to LAs was accompanied by changes in their relationships with the NHS, and although DsPH continued to provide a well-used service to CCGs, they often felt under-staffed to meet the needs of CCGs. The multiplicity of LA/CCG relationships remained a problem – especially in county areas; this previously would have been addressed at a regional level.

7.3.5 *To what extent was there a shift in approach or a move towards new ways of working across the local public health system?*

The results from our surveys supported case study findings that public health teams were making changes in commissioning for health improvement. These were particularly taking place in authorities where DsPH felt they had influence, where HWBs were having an impact and where there was a culture of collaboration between LA departments. Survey results showed that the majority (96% of DPH respondents in our 2015 survey, 94% in 2014) of councils reported changes such as new, re-designed, or de-commissioned services under the ring-fenced public health budget. Results showed that levels of change were already high in 2014, and in 2015 they continued to increase with more DsPH reporting having changed providers and de-commissioned services.

In our study we were keen to explore whether bringing public health into LAs improved relationships with other LA services such as education and planning and transportation. We found that much of the work with schools predated the 2013 reforms. Over the course of our research we identified some improvements in relationships between public health and other LA departments. For example, we did identify some positive developments where public health teams were working with planning through the production of SPDs and training and information, and a willingness of planners to involve public health officers. As yet, these links were not well developed. However, the reforms had also disrupted networks and relationships established when public health was located in PCTs.

There was also a particular problem in two-tier council areas as public health officers sit with county councils and planning officers sit within with district councils, creating additional complexity.

In the second phase of our research we explored how the shift of public health from PCTs to LAs was affecting the commissioning and provision of weight management and obesity services. We explored how public health teams were working with other parts of local government and the NHS (local CCGs) through a focus on services in schools, working with planning on tier 1 population prevention measures, and commissioning across tiers 3 and 4 of the obesity pathway. The findings from this element of the research provided some detail to our general examination of inter and intra-organisational arrangements and developments. In addition we also identified some specific issues relating to the commissioning of services that were discussed in section 6. Key issues included:

- There was some evidence that LAs were beginning to think about strategies across the whole council. Developments still lacked coordination, and despite some rhetoric about ‘whole system approaches’, they were still mainly preoccupied with individual behaviour change interventions.
- We found substantive evidence of significant changes to the commissioning of obesity services. There was evidence of shifts in investment and some broad strategic approaches such as to weight management or supporting work in schools (although this tended to build on pre-existing developments). However, there was confusion regarding the commissioning and resourcing of tier 3 services. There was also some disinvestment by some LAs with cuts in expenditure.
- Findings from our case study sites showed that there was still a lack of clarity about commissioning responsibilities in relation to tier 3 services for obesity. In addition, a number of respondents reported capacity issues with insufficient staff to deliver initiatives. Public health teams generally reported a high demand for their services which they struggled to meet. Changing structures within public health teams – particularly the shift from public health practitioners to commissioning or business managers - was having an impact on the provision of specialist public health services.

7.4 Conclusion

While our research has provided only a limited overview of the development of the public health system in England between April 2013 and the end of 2015, our findings have highlighted some important issues that have both policy and practice implications. Support for a stronger LA role in public health was widespread but how the public health function and responsibilities were being developed varied considerably. We found distinct differences between authorities and there was no one specific factor that led to such differences. However, a key finding of the research was that the system continues to be in a substantial state of flux. This was due to the initial degree of fragmentation and complexity in the commissioning and provision of public health services

introduced in 2013, and some continuing confusion about organisational responsibilities in terms of commissioning (eg the obesity pathway). Since 2013, there have been changes in responsibility for commissioning some aspects of public health services and substantial re-organisation both in PHE and in local government. Two-tier councils faced particular challenges in co-ordinating public health activities and there remain problems in supporting CCGs.

Competing policy initiatives have also led to local authorities, and particularly HWBs, focusing on specific government initiatives such as the Better Care Fund, at the expense of broader health and wellbeing improvement. Our findings suggest that while LAs had recognised the importance and value of public health, service integration and funding have dominated joint working agendas. There was an ongoing struggle between local agendas (e.g. tackling inequalities) and a central government push (e.g. towards integration) where HWBs can only be a part of the solution; this suggests that HWBs may be best focused on their local system oversight and co-ordination roles. Whilst the context of reductions in resources and financial constraint was forcing some local systems to examine novel approaches to commissioning and provision, in general, it did not facilitate joint working and can lead to suspicion locally between organisations about potential budget raids.

Government announcements in 2015 regarding cuts to the public health budget were a clear concern - particularly in the context of wider local government finances. While budgets for public health remain ring-fenced for now, it is clear from our research that budgets were being used flexibly at a local level. In some cases, this led to innovative use of resources, but in other areas, concern was expressed about misuse of public health funding. Financial constraint also had an impact on the capacity of public health teams - how they were organised and their position in local authority structures. Coupled with broader financial constraint in local government, the impact of budget cuts led to continuing restructuring and organisational change. It is likely that this state of flux will continue in the near future, limiting capacity and ability to fulfil all demands being made on public health teams.

We found that other departments in local authorities were responding in different ways to having a public health resource, and there are examples of collaborative working developing in areas such as planning. These remain limited at the moment, but the recent announcement of the NHSE and PHE 'healthy towns and places' initiative may provide further impetus in this area. We also found examples of new service developments and the continuation of partnerships developed before 2013 – particularly in relation to schools and sport. Conversely, working with CCGs and the NHS remained a key concern with some public health teams struggling with capacity and in some areas poor linkage between CCGs and public health.

The changes brought about by the HSCA12, and the implications for the organisation and delivery of the public health function, have been profound. Examining the impact of such changes through research has been extraordinarily challenging, particularly given the broader changes to the health and social care system, and indeed, to other government policies in areas of education, welfare and so on. Our research points to the importance of systems thinking (Trochim et al 2006). The use of the term 'the public health system' to describe what in reality is "a chaotic, sprawling, dynamic set of practices which are often intensely political, and a set of activities that might more closely resemble

a non-system” (Hunter et al 2010:3) is inherently problematic. However, systems thinking focuses on inter-relationships, and emphasises holistic thinking from multiple perspectives.

Drawing on systems thinking in our research, we have developed an emerging understanding of the complexities of what we refer to as ‘a public health system’. When looking for improvements in system design, it is crucial to understand and consider the complex network of individuals and organisations that have the potential to play critical roles in creating the conditions for health. It is also crucial to consider how they might best be supported and encouraged to work together, to act as a system. Within the HSCA12 and associated policies, insufficient attention was paid to the nature and quality of relationships across the various organisations and individuals, and the overlaps, gaps, synergies and contradictions amongst their roles and responsibilities that ultimately determine the effectiveness of ‘the system’. Consequently, whilst some of the challenges identified during the passage of the health and social care bill have been averted, many remain. And whilst some of the opportunities identified have been realised, many are highly dependent on a range of locally contextual factors, and most are simultaneously threatened by conflicts and negative feedback loops within the system. It will be important to continue to examine the ways in which the public health system continues to adapt and change, and the implications of these adaptations for public health activity and public health outcomes.

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