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PUBLIC HEALTH AND OBESITY IN ENGLAND – THE NEW INFRASTRUCTURE EXAMINED (PHOENIX)

FIRST SURVEY REPORT: FINDINGS FROM A SURVEY OF DIRECTORS OF PUBLIC HEALTH AND ELECTED MEMBERS

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Report available at: **http://www.prucomm.ac.uk/projects/current-projects/phoenix.html**

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List of Abbreviations

ADPH	Association of Directors of Public Health
CCG	Clinical Commissioning Group
DH	Department of Health
DPH	Director of Public Health
DQ	DPH survey question number
DsPH	Directors of Public Health
EQ	Elected member survey question number
HWB	Health and Wellbeing Board
LA	Local authority
LGA	Local Government Association
NHS	National Health Service
NHSE	National Health Service England
PHE	Public Health England

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

First survey report: findings from a survey of directors of public health and elected members

Executive summary

This report presents the findings of two surveys conducted as part of a larger Department of Health funded project (PHOENIX), examining the impact of structural changes to the health and care system in England on the functioning of the public health system, including the approaches taken to improving the public's health. The surveys reported here sought the view s of directors of public health (DsPH) and elected members (i.e. councillors) with a responsibility for public health in the 152 English unitary and upper-tier authorities. They were asked about the position and status of public health within their authority, the organisation of the public health team, use of the ring-fenced budget, internal relationships such as committee membership and Health and Wellbeing Boards (HWBs), and external relationships with Clinical Commissioning Groups (CCGs), Public Health England (PHE), etc., and whether there had been changes in commissioning since April 2013.

There were 96 usable replies to the DPH survey (response rate 63%) and 54 usable replies to the elected member survey (response rate 36%). In total we had at least one reply from a DPH or councillor from 115 local authorities (76%), and for 34 (22%) authorities we had a reply from the DPH and the councillor. The distribution of responses was representative of England in terms of geographical region, type of local authority, political party in power, population size, levels of deprivation, levels of obesity and per capita public health budget.

Despite the turbulence of the reforms, both public health leaders and elected members seemed very positive about the way public health teams had transferred and become embedded in local authorities. The new arrangements for public health varied, with the majority being placed in a larger directorate, such as adult services, and some remaining as a distinct public health directorate. Each arrangement appears to have both advantages and disadvantages. For example, where the public health team is not held in 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 has a direct reporting line to the Chief Executive

The survey results indicated that the transition had gone well, that public health had been welcomed and that their skills and services had been valued and used within the authority. Successful integration appears to have been helped by a number of factors, such as high quality leadership, strong organisational arrangements and clear lines of reporting, shared goals and public health actually delivering good quality work. Elected members felt there was mutual respect between themselves and DsPH, and they welcomed the funding that came with public health. Clearly the move was not helped by occurring at a time of massive budget cuts in local government, and both

DsPH and elected members cited the historically different cultures and ways of working that made successful integration of public health challenging.

The shift of public health teams to local authorities 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. DsPH also felt poorly supported by national and regional organisations such as the Department of Health, NHS England and PHE - a perception echoed by elected members who felt they had received little help apart from that provided by the Local Government Association.

Both DsPH and elected members welcomed the widening of their influence following the reforms, through new lines of communication and their membership of the Health and Wellbeing Board. DsPH were rather more sceptical than elected members about what the HWB was achieving, but they were both very positive that sitting on the HWB enhanced their influence over their organisation and across the system.

With regard to control over public health spending, DsPH felt they largely had control, but in reality this was often subject to council policy and procedures over authorising expenditure, or subject to cabinet ratification. Nevertheless, many councils reported changes such as new, re-designed, or de-commissioned services under the ring-fenced public health budget. After a slow start, by summer 2014, many reported having made changes in commissioning for health improvement, and these were taking place particularly in authorities where DsPH felt they had influence, that HWBs were having an impact and where there was a culture of collaboration between local authority departments.

1 Introduction and background

1.1 Context, aim and purpose of surveys

This report presents the findings of two surveys conducted as part of the PHOENIX project. The PHOENIX project is examining the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health. The study incorporates multiple methods, including key informant interviews, document analysis, local case-studies and national surveys (Gadsby et al 2014; Peckham et al 2015). This report details the findings of the first of two national surveys of Directors of Public Health and elected members (councillors) with a responsibility for public health in the 152 English unitary and upper-tier authorities. This first survey was undertaken through July/August 2014. The focus was on exploring the impacts of structural changes at national, regional and local levels on the planning, organisation, commissioning and delivery of health improvement services. The aim was to examine these broader relationships in order to capture different organisational arrangements in local government and the NHS.

The surveys were designed to complement other parts of the study, describe the national situation, provide background and context for the case study sites, identify change over time, inform the case study research, and test out findings from other parts of the study (scoping work and case studies). A second round of surveys will be undertaken in September 2015.

1.2 Review of other similar research

We carried out a scan of existing research on the implications of the reforms for public health staff, structures and practices. We found several surveys covering a similar area to our own study, and the types of questioning and response rates of these informed the development of our survey design.

Studies relevant to this research had focused mainly on the views of people working in public health in England. They found public health teams in a wide variety of different structural and managerial arrangements following the move to local government, and highlighted opportunities and challenges (Association of Directors of Public Health 2014, Mansfield 2013, Royal Society for Public Health 2014, Jongsma 2014, Humphries & Galea 2014, Iacobucci 2014). Findings from these studies included: that councils had welcomed public health teams; that relationships were still developing; that public health had good access to councillors; that public health had an increased ability to have an influence more widely within the authority and beyond; and that changes in commissioning for health improvement were slow to start. The studies raised several concerns: that HWBs lack statutory powers that could affect their impact; that public health teams would find big cultural differences and need to change the way they operated; that the ring-fenced budget could be misappropriated; and that the enormous financial pressures within local government could lead to further organisational change.

The views and experiences of local authority councillors had been researched to a lesser degree and could be seen in a small number of case studies (Local Government Association 2014a, Local Government Association 2014b).

2 Methods

2.1 Survey design

An online survey approach was chosen utilising a specialist software package (Survey Monkey). Survey Monkey was chosen as it is designed to generate professional survey formats, and allow personalised emails to be sent inviting individuals to take part.

The survey was to cover all local authorities in England with public health responsibilities (i.e. upper-tier and unitary), and obtain multiple perspectives on the move of public health teams to local authorities. Given the extent to which those involved in the move of public health to local government were being scrutinised, we were concerned that our survey would add an unwanted and unwarranted burden, unless it asked new questions and was able to provide new information. Therefore we decided that the 2014 survey would focus upon the key actors in public health - DsPH and elected members leading on health / public health - and would be more in-depth than other surveys.

As there were only 152 local authorities with directors of public health and because we expected a 50-70% response rate from DsPH, it was decided to include all DsPH in the survey sample. There was little evidence on which to base a response rate for elected members, but we judged it to be between 25-50%, so decided to survey the elected member with the health / public health portfolio in the same local authorities as we had for DsPH.

Research ethics approval was obtained from the University of Kent (SRCEA No. 112).

2.2 Mailing lists

The survey was personally addressed to potential participants via their email address. Up to date lists of DsPH and their email addresses were obtained from the Association of Directors of Public Health (ADPH). Each upper tier and unitary authority must appoint a Director of Public Health. The names of local authority elected members leading on health / public health were obtained from local authority websites. For the great majority of local authorities, the name and contact details of the person with responsibility for health or public health could be found in this way. When there was no explicit health lead we either took the name most likely to have that responsibility or contacted the local authority for names and email addresses. To allow for the fact that a small proportion of elected members change after local elections held in May each year, we tried to reduce the chance of sending to people who were newly elected and had no experience of holding the health portfolio. Therefore in year one of our survey (mailed out in June 2014), in the areas where 100% of council seats were up for re-election, we extracted the names of elected members leading on health before the May 2014 elections.

2.3 Topics, questions and question wording

While our survey needed to address the research aims of the PHOENIX research proposal, we also wanted to focus upon pre-existing research to inform its development. This helped us deal with issues such as what topics had been covered in recent surveys, how questions were worded, how well and what type of questions worked, response rates, findings, how much overlap there was with

the questions we wanted to ask, the effect of survey fatigue, if we could access and use results from other studies, and so on. Despite the subject being under heavy scrutiny from researchers, we decided against developing a very quick and easy survey to respond to, but one that would be more nuanced and provide us with more substantial replies even though the time required might risk a lower response rate. We decided a longer set of questions was necessary and acceptable for DsPH compared to elected members. Although elected members leading on health / public health would be interested in the subject we expected they would be less willing/able to spend time completing our survey. We wanted to ask questions of importance to the study aims even if they had recently been asked by other researchers, because in some cases we wanted to examine the situation in greater depth, and compare experiences within the same authority. Two separate questionnaires were therefore required with a set of core questions appearing in both.

Some aims of the research were quite specific (how PH teams were organised, provide support and were consulted), whereas others were quite broad (about relationships, adapting to a new culture of working and influencing others). We decided it was legitimate to include some of the broad and less well-defined areas in the survey, especially when these had been raised in the scoping review (Gadsby et al 2014), as long as the question could be asked sufficiently clearly and it was not difficult to answer.

The longer survey for DsPH asked about the position and status of public health within the authority, the organisation of the public health team and the ring-fenced budget, internal relationships such as committee membership and Health and Wellbeing Boards (HWBs), and external relationships with Clinical Commissioning Groups (CCGs), Public Health England, etc. (see questionnaire in Appendix 2). We also asked about changes in commissioning since April 2013. The shorter survey for elected members asked similar questions about the position of public health in the authority, the budget, relationships, and the HWB (see questionnaire in appendix 3). They were also asked about new approaches to commissioning for health improvement.

External advisers and experts were consulted at various stages in the process of survey design, for example on how it was administered, the topics included and the question wording. Advisers included Nicola Close (ADPH), Dr Marion Gibbon, David Hunter (Durham University), Paul Ogden (Local Government Association), Cllr James Walsh and Jamie Blackshaw (PHE).

2.4 Administering the questionnaire

The surveys were piloted in the 5 case study sites where we were already working. The pilot showed that the responses we received were of good quality, and as expected, the response rate for elected members was quite low. In the light of the pilot we went ahead with the main survey with slight adjustments to the timing of the reminders.

The DPH survey was sent to named individuals in 152 authorities, and the elected member survey to named individuals in 150 authorities (the post could not be found in the City of London or the Isles of Scilly). The surveys were sent out under a personal email from the PHOENIX study principal investigator, containing a link to complete the survey online. In situations where a DPH was appointed across more than one authority, they were sent a separate email for each authority and asked to either make a separate response for each authority, or to nominate another respondent in

each specific authority. In one authority, the health portfolio was shared between more than one councillor, so they were all asked for separate responses.

The fieldwork started at the end of June and two reminders were sent out at approximately two week intervals – shorter for DsPH and longer for elected members. A third reminder was sent to the elected members at the start of September 2014. Fieldwork ceased when responses were no longer forthcoming.

2.5 Handling responses and analysis plan

Survey responses were recorded online then downloaded into a statistical software package (SPSS) to aid analysis. The DPH survey provided 109 closed or 'tick box' responses and 39 open-ended replies. The elected member survey provided 60 closed and 30 open-ended responses. Datasets were combined, checked and cleaned. Particular attention was paid to check the authorities with a shared DPH so that replies were attributed to the correct authority, and to combine responses for authorities where duplicate replies had been made. Variables were added to the survey data sets to describe contextual characteristics, such as geographical, population, political and social characteristics. Other added variables were derived from the survey replies where that would aid the analysis or interpretation, for example, combining answers across several questions, or combining categories of response to make scales easier to use and reduce the impact of small numbers.

Survey results consisted of descriptive tabulations illustrating the national picture of responses and summarising the content of free-text comments, and comparisons of the perspectives of different actors in local authorities. Further analyses explored how these related to other characteristics, such as different features of local authorities, and the new public health structures, relationships and ways of working.

3 Results

The survey findings are given below in sections covering: the organisational arrangements for public health within local authorities; their developing relationships, ways of working and influence over budgets; relationships with external organisations; role of the health and wellbeing board; support given to clinical commissioning groups; and emerging changes to commissioning for health improvement. Some of the questions were only posed to DsPH, but when the same or similar questions were asked of DsPH and elected members the results include both in order to highlight how they differed. A separate analysis was carried out on the authorities where we had both perspectives, partly as a check that the differences we had observed overall were not simply due to the different samples of local authorities responding to the two surveys, and partly to see how similar the two perspectives were in individual authorities.

In addition, some tests of association have been carried out on the DPH survey data to examine relationships between the type of authority, whether there had been changes in the way the public health budget was spent, and whether DsPH felt the reforms had given them greater influence.

The results section concludes by summarising the main findings.

3.1 Respondent details

In the survey of DsPH there were 97 responses (96 usable replies, response rate 63%); and for the elected member survey, we received 56 responses (54 usable, response rate 36%). 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. One DPH (responsible for three authorities) opted out of our survey, and three elected members leading on health had already opted out of doing any surveys utilising the Survey Monkey platform. Overall we received at least one response from 115 local authorities (76%), and have both DPH and elected member perspectives in 34 (22%) authorities.

For the survey of DsPH, there was a very close correspondence between the distribution of replies compared with the whole of England in terms of region, type of local authority, political party in power, population size, levels of deprivation, levels of obesity and per capita public health budget. The same was true for elected members, see figures 1-5.

Figure 1: England regions: comparison of survey responses to national distribution (% of N=96 DsPH and N=52 elected members)

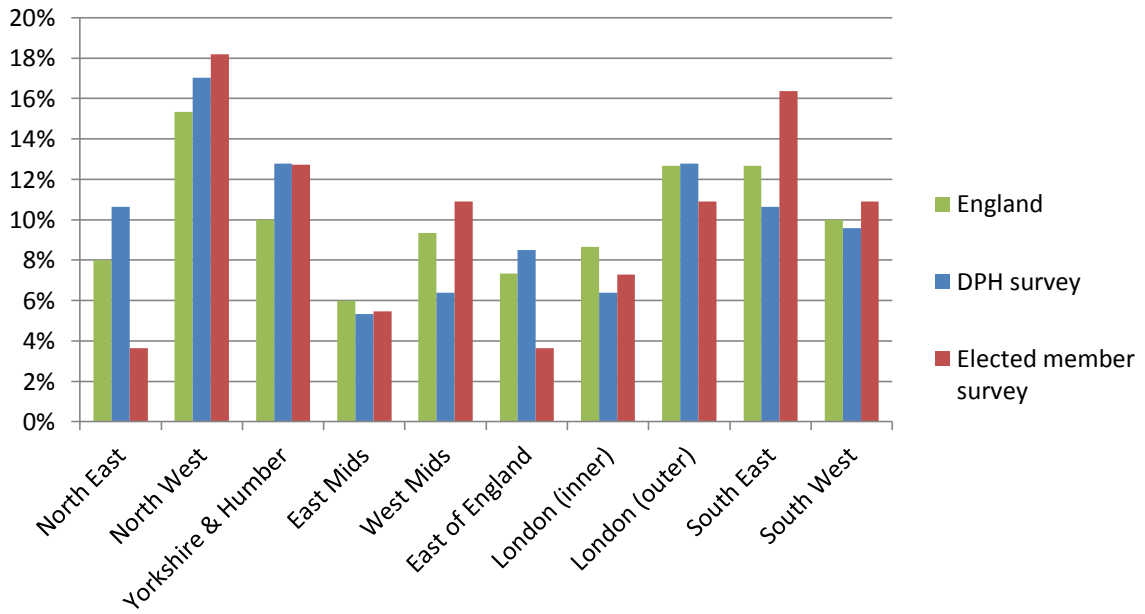


Figure 2: Types of local authority: comparison of survey responses to national distribution (% of N=96 DsPH and N=52 elected members)

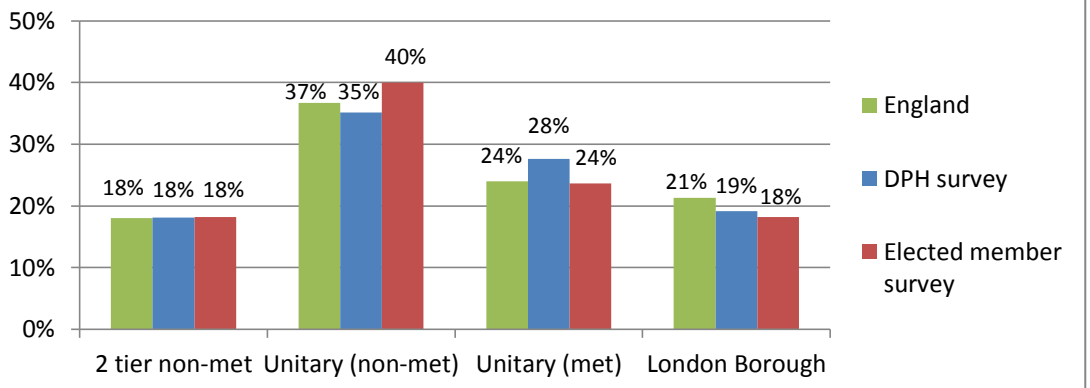


Figure 3: Political party in power: comparison of survey responses to national distribution (% of N=96 DsPH and N=52 elected members)

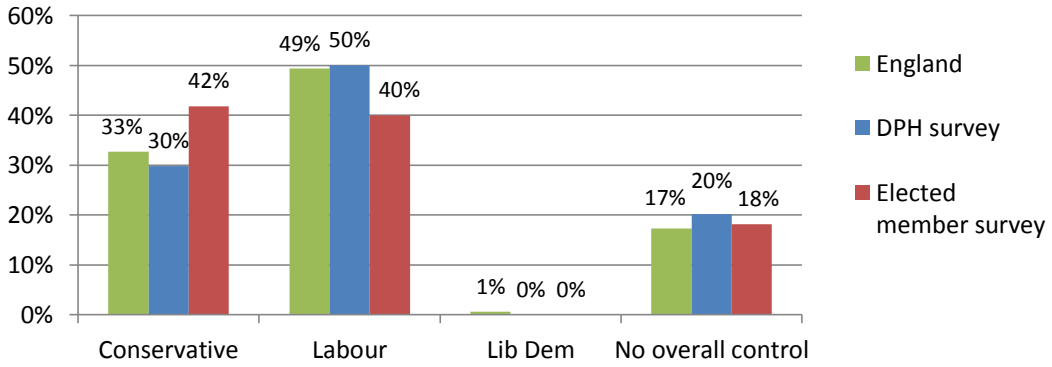
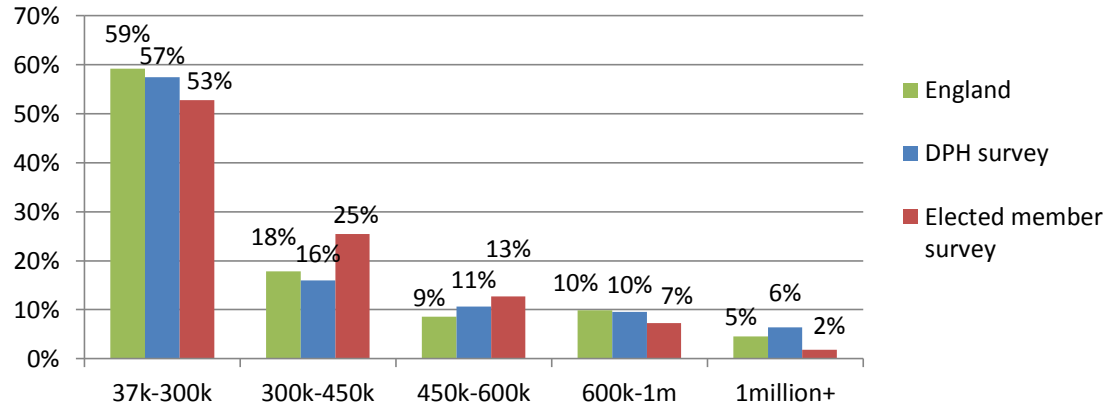
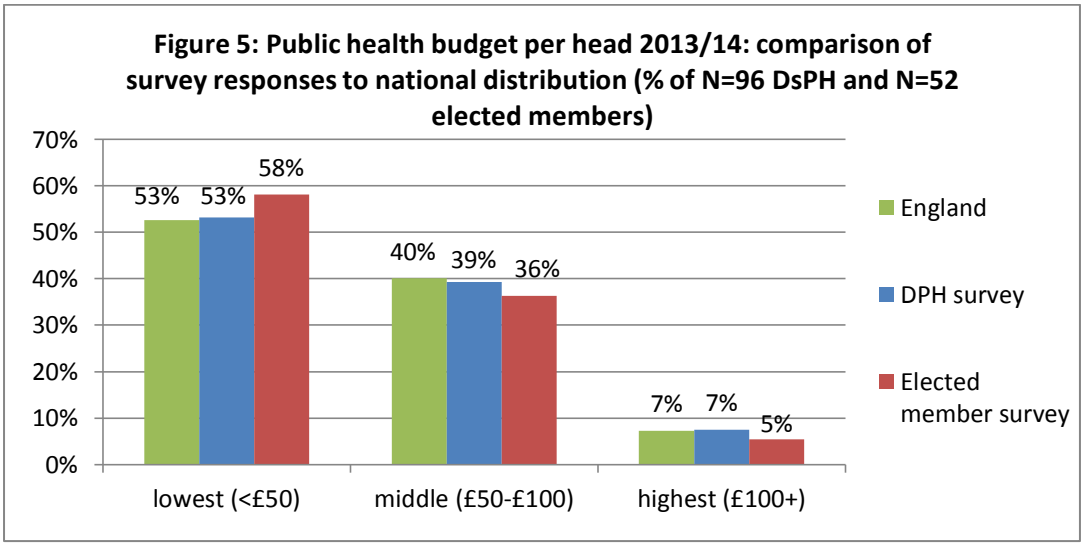


Figure 4: Population size: comparison of survey responses to national distribution (% of N=96 DsPH and N=52 elected members)



The ring-fenced public health budgets allocated to local authorities for 2013-2014 were determined by a policy whereby historical allocations are gradually increased towards a target per capita allocation. In 2013-14 the allocations to England local authorities ranged from £20 to £130 per head (excluding City of London), and averaged £49 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190640/Public_Health_Grants_to_Local_Authorities.pdf).

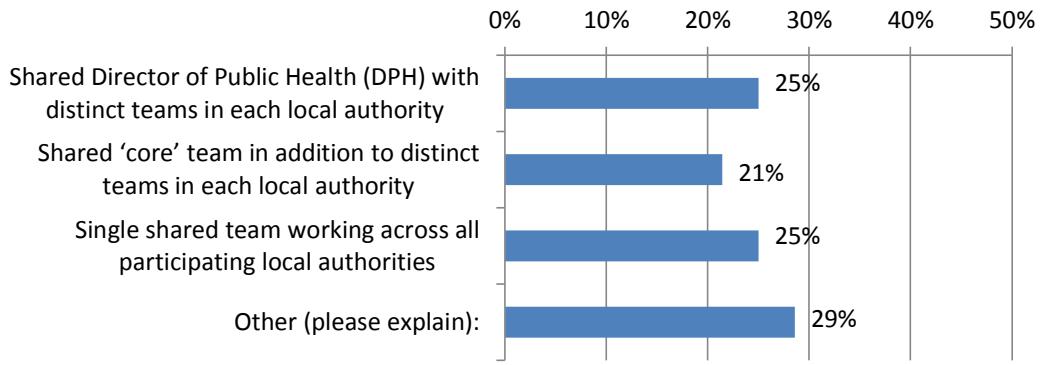


3.2 Organisational arrangements for public health within local authorities

Full details of responses to questions about the organisational arrangements are provided in the frequency tables for DQ1-16 and EQ1-3 in Appendix 1. (DQ refers to the DPH survey question number, EQ refers to the elected member survey).

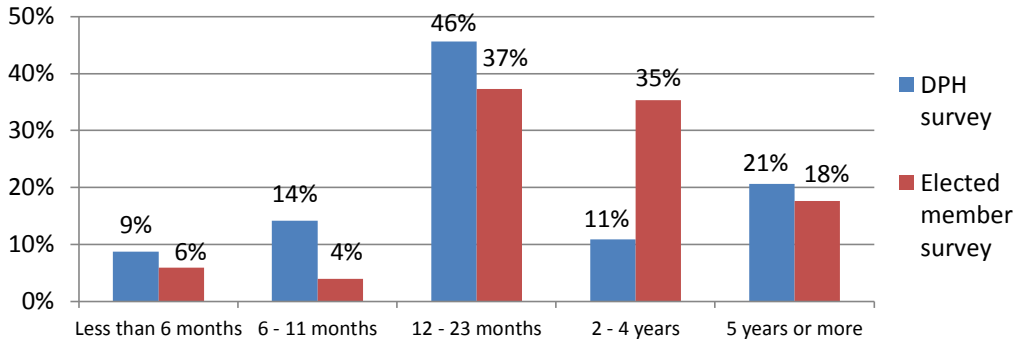
It was quite common (32%, DQ1) for a local authority (LA) public health team to be part of a sharing arrangement delivering the service between several upper tier authorities, and these arrangements were nearly all permanent (96%, DQ3). Sharing was often between two local authorities (52%, DQ2), but the number of authorities involved ranged from two to eleven. There was no predominant model for sharing. More common arrangements included: a single team working across all authorities; a single director with teams in each authority; or a core team working with distributed teams. 'Other' arrangements included a mixture of core and local team responsibilities, or different arrangements for specific services (DQ4 and figure 6).

Figure 6: What is the nature of the sharing arrangement?
(% of N=28 DsPH)



Most replying to the DPH survey were DsPH (85%, DQ7), with 7.5% acting or interim DsPH, and 7.5% other posts including PH consultants and deputy directors. All but four of the elected members (93%, EQ2) were members of the council cabinet or executive, nearly all had the public health or health and wellbeing portfolio and/or adult services portfolio. Many DsPH were experienced, with 62% having five or more years at that grade, although a quarter had less than two years as a DPH (DQ6.2). In local government, nearly half the DsPH (46%, DQ6.1) had been in the same local authority for 1-2 years, 11% for 2 or more years, and 23% less than 1 year. See figure 7.

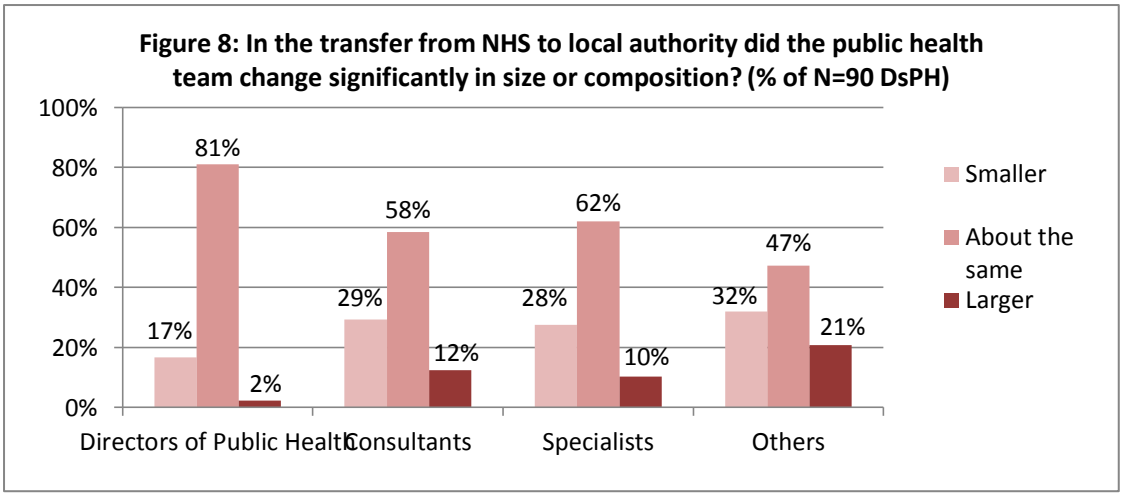
Figure 7: Length of time as DPH/health portfolio lead in the authority
(% of N= 92 DsPH and N=51 elected members)



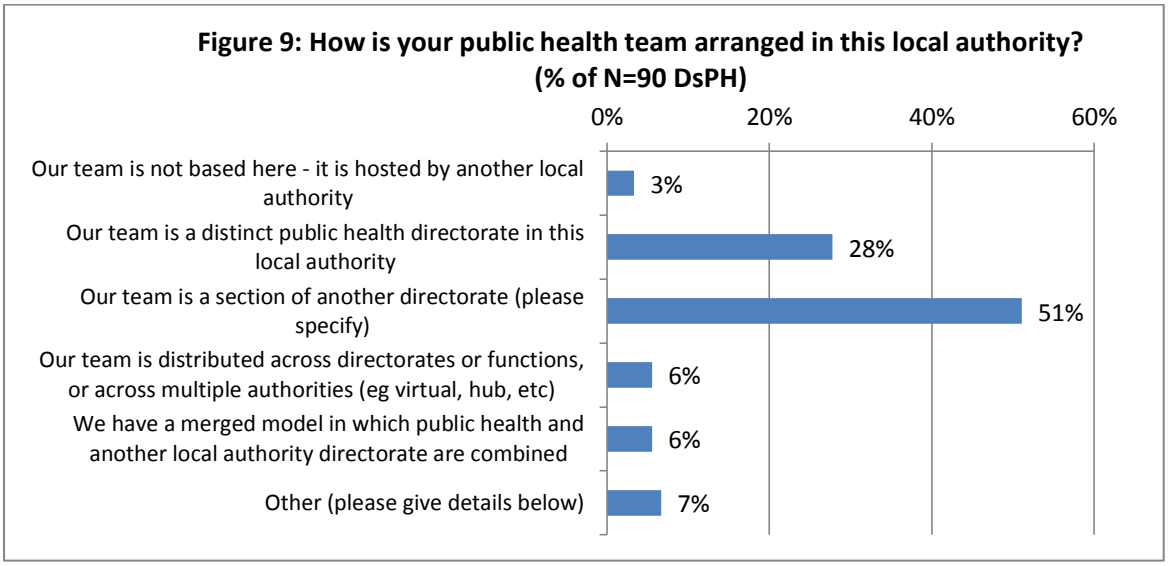
By combining the two questions, the survey showed that only 71% in the DPH survey were experienced at their grade and also had 1 or more years' experience in their current authority, compared with 96% of elected members who were on the council cabinet / executive and had at least a year's experience in the authority (DQ/EQ grade & experience). Elected members (unsurprisingly) generally had longer experience within the local authority, and over half (53%) said they had held the health portfolio for two or more years (EQ3.3).

The DPH survey asked about staff numbers before and after the reforms. In most cases, teams remained 'about the same' or were 'smaller' (DQ8 and figure 8); 17% reported a reduction in DPH posts and about a third (32%) said there had been staff reductions in the other categories of staff. At the same time, there was some growth in staff numbers - mainly among 'other', non-specialist

public health roles. The comments showed changes were due to a mix of factors such as sharing, merging and down-sizing decisions, and staff transfers.



We asked about the arrangement or location of PH teams within their local authority. The replies showed that the usual arrangement was for a distinct team as a section of another directorate (51%, DQ9 and figure 9), with public health remaining as a distinct directorate being the next most usual (28%). The free-text comments showed that when part of another directorate, public health was located in a very wide range of directorates including the Chief Executive's office, commissioning, corporate strategy, housing, but more usually they were in health and wellbeing and adult services directorates and others including neighbourhoods, communities and families.



Just over a half the DsPH said they had formal strategic alliances with public health teams in other authorities (DQ10). The comments showed there to be a range of alliances, networks and collaborative arrangements in all parts of England, and that these were seen as helpful and supportive. Some were well-established and some described as informal. The larger ones were across several counties or boroughs and in the case of Manchester, across all 10 unitary district councils.

Two fifths (42%, DQ11) of the DsPH were managed by the Chief Executive, and this was usually the case in authorities which had created a separate public health directorate, but could also happen when public health was a section within another directorate. Over half (55%, DQ12) of DsPH were on the authority's most senior corporate management team, and this percentage rose to 87% for those managed by the Chief Executive (DQ11 by DQ12, p=0.000), and 84% for those in a distinct public health directorate (DQ11 by DQ9). For some of those who were not on the senior corporate management team, this was not perceived to be a problem as they were able to see the associated papers and attend meetings. However, a small number (6) were frustrated by lack of access to this forum.

All but one (99%, DQ13) in the DPH survey said they had access to elected members, particularly those with responsibilities for health, and nearly half elaborated on this saying they had access to others such as the leader, other cabinet members and all elected members. Many of their comments reinforced that access to members was unrestricted and worked well (DQ14-15).

While most DsPH respondents said their role covered all the core statutory responsibilities, there had been change for 70% of authorities with a mixed picture of DsPH gaining, losing and sharing responsibilities since moving into the local authority (DQ16.1-16.4). In two-tier authorities, the public health team was more likely to have gained responsibilities, whereas in London Boroughs, they had not been given more responsibilities (p=0.008). The DPH was more likely to shed some responsibilities when public health was not a distinct directorate (p=0.037). The comments showed that additional responsibilities included community safety, emergency planning, environment, leisure, and children's commissioning. Responsibilities that had moved away were usually drugs and alcohol.

3.3 Developing relationships, ways of working and influence over budgets

Full details of the responses to questions about relationships and ways of working within an authority are provided in the frequency tables for DQ17-31, EQ4-17 in Appendix 1.

The survey asked how well public health teams had become embedded in local authorities. Both DsPH and elected members thought that public health staff had built good relationships, with 79% of DsPH and 70% of elected members saying 'yes - definitely', and most of the rest saying 'to some extent'. Other responses were positive, but split more evenly between 'yes - definitely' and 'to some extent' that public health staff were valued across the authority (42% DsPH said 'yes – definitely', 49% said 'to some extent', with corresponding figures of 53% and 45% for elected members), that staff in other departments asked for public health advice (48% DsPH said 'yes – definitely', 49% said 'to some extent') and that they trusted public health advice (58% DsPH said 'yes – definitely', 41% said 'to some extent'). DsPH were least positive about whether staff in other departments knew what public health staff could offer, with only 14% saying 'yes - definitely', and 78% saying 'to some extent'. (DQ17.1-5, DQ17, EQ4.1-2)

The DsPH' comments showed that even in authorities where good progress had been made in embedding public health, there were limitations, such as relationships being slow to develop, or there were barriers due to re-structuring, staff losses and people working in 'silos'. Where the

embedding had been less successful, the DsPH' comments indicated that there had been a hung council, a poor transition, or poor structures, but these difficulties did not seem to be widespread. Comments from elected members were broadly positive about public health working well.

Both DsPH and elected members were asked to give what they felt were the three main enablers and three main barriers to the public health team becoming successfully embedded in their local authority. The view of DsPH (summarised in table 1 below) was that it was most important to have high quality leaders and champions of public health, which might include the Chief Executive, and a commitment to public health in the authority. Other enablers were having strong organisational arrangements and clear procedures, followed by adequate funding and a public health team that had been able to demonstrate the value of their work. The main barrier was seen to be budget cuts. The other barriers were a lack of common culture, an unwillingness to change, and a lack of understanding of public health. To some extent, the same issues can be seen as both a barrier and enabler (appearing in both lists), but their relative importance can change according to whether they are seen as positive or negative influences.

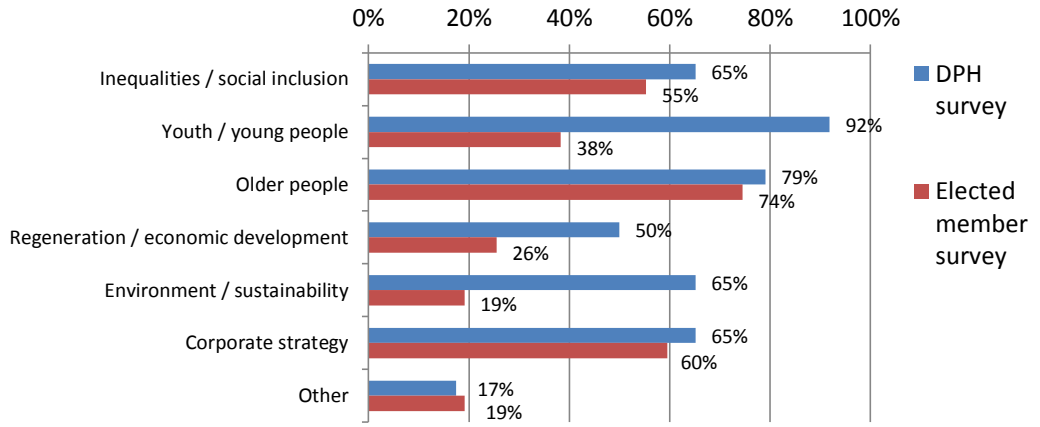
Table 1: Themes from an analysis of DsPH' comments on enablers and barriers to public health becoming successfully integrated.

The three main ENABLERS for PH becoming successfully integrated in your local authority (DQ18 ranked high-low in number of responses)	**The three main BARRIERS to PH becoming successfully integrated in your local authority** (DQ19 ranked high-low in number of responses)
Theme 1: High quality staff and leadership, eg high level champions, DPH, team attitude. Theme 2: Competent reporting lines/working relationships/organisational arrangements. Theme 3: Good strategy/ corporate procedures/shared goals/ clarity. Theme 4: Adequate budget. Theme 5: Delivering quality work/ demonstrating good skills/ making an impact. Theme 6: Smooth NHS to LA transition. Theme 7: Soft skills.	Theme 1: Budget cuts. Theme 2: Ways of working, e.g. lack of integration/ shared goals/ culture clash. Theme 3: Unwillingness to change ways of working/ attitudes to change. Theme 4: Understanding of PH. Theme 5: Communication lines & role organisation. Theme 6: Capacity and resources. Theme 7: Team competency. Theme 8: The NHS to LA transition.

Elected members highlighted a smooth transition and relationship building within the authority as important enablers, as well as a mutual respect, understanding and commitment to public health. The public health budget was also seen as helpful in terms of providing additional resources for local government. In relation to barriers, elected members did not place budget cuts at the top of the list, but saw the main barrier as the need for public health to lose its NHS mind-set and adopt new ways of working. Next in importance were the barriers due to a lack of understanding of public health within the authority, and the budget cuts.

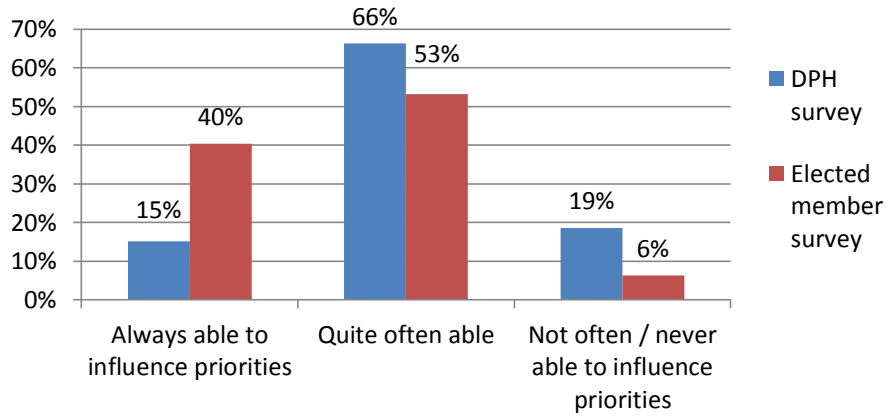
There was good representation of DsPH on cross-departmental groups or committees, with 92% being on committees for youth/young people, 79% for older people, and between 50%-65% on inequalities/ social exclusion, environment/ sustainability, corporate strategy and regeneration/ economic development (DQ20). 'Other' groups that DsPH said they sat on included Community Safety. Elected members leading on health were less prominent on some of these groups, but 74% sat on cross-departmental groups for older people, 60% on corporate strategy, and over half on inequalities/ social exclusion (55%, EQ7). See figure 10.

Figure 10: Within the local authority, do you sit on cross-departmental groups or committees focusing on the following areas? (% of N=96 DsPH and N=53 elected members)



DsPH were asked how able they were to influence priorities in their local authority, with one in seven DsPH (15%) feeling 'always able', two thirds (66%) 'quite often able' and nearly one in five (19%) 'not often able' or 'never able' to influence priorities. DsPH' comments reinforced that being influential could be difficult and was going to take time. When asked the same question, elected members felt more confident in their powers to influence priorities and their comments highlighted the benefits of having established good relationships, including with public health (DQ21, EQ8, and figure 11).

Figure 11: To what extent do you feel able to influence the priorities of your local authority? (% of N=86 DsPH, and N=47 elected members)



Elected members were also asked the extent to which they felt able to influence the priorities of the public health team in regard to public health. They gave similar replies to the more general question just described – 43% 'always able', 52% 'quite often able', and 6% 'not often able'/'never able' to influence the priorities of the public health team (EQ9).

The survey asked more about their influence and ability to deliver health improvements, and whether this had changed since the April 2013 reforms. Elected members were very positive and felt more empowered within their authority and beyond, and also through their new contacts with

CCGs. Most DsPH (82%) saw the benefit of their new location to have an impact within the authority and saw themselves as more able to improve health with their recent integration into the local authority and beyond, such as workplaces and schools. However there were some trade-offs for DsPH especially in the large proportion (37%) who felt less able to influence the work of CCGs (DQ22, EQ10 and figures 12 and 13).

Figure 12: To what extent do you (DPH) feel able to deliver real improvements in local health by: (% of N=83 DsPH)

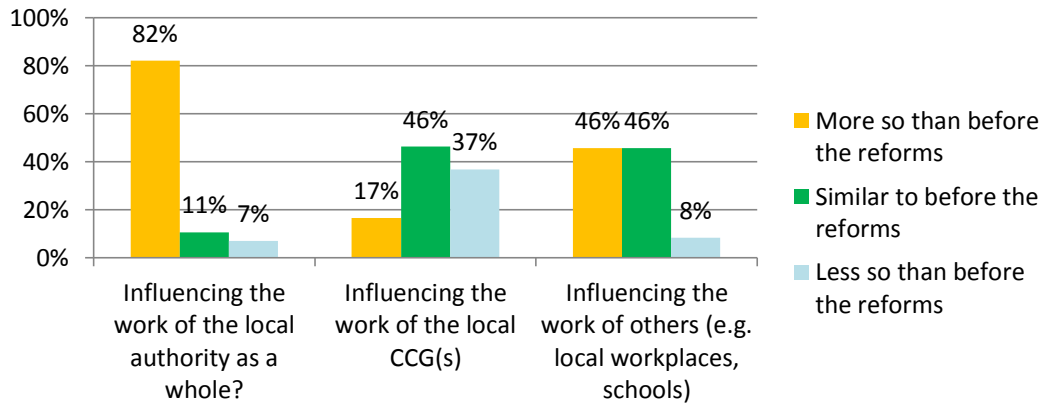
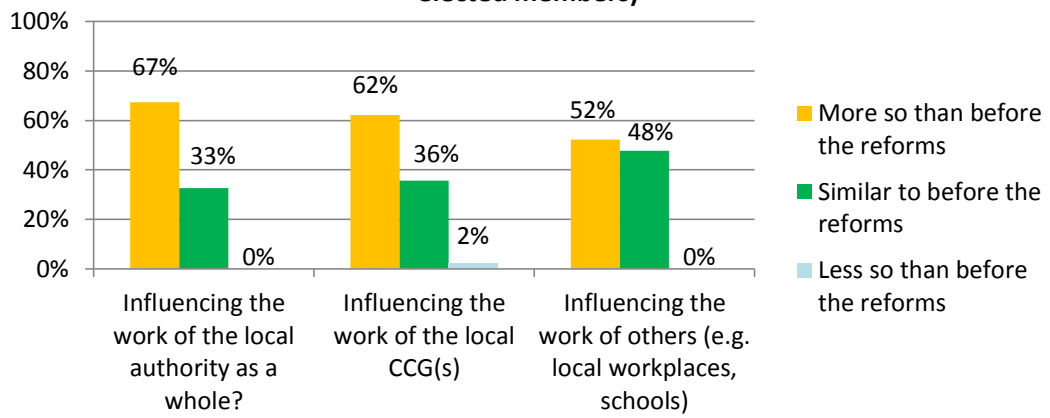


Figure 13: To what extent do you (member with health portfolio) feel able to deliver real improvements in local health by: (% of N=46 elected members)



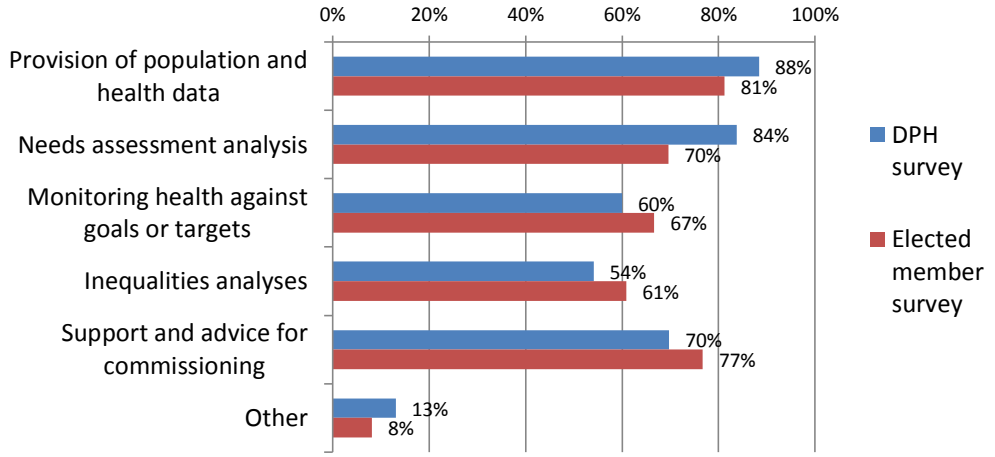
For more detailed work on the influence of DsPH, see section 3.9 and Jenkins et al (2015).

The DPH survey asked if there was a requirement for other departments in the local authority to collaborate with public health on their plans. Many said there was 'no' requirement (39%), 39% said 'yes – but only under certain circumstances', 15% said 'yes – always', and 15% said 'other' (DQ23). The comments gave a more positive view as when there was 'no' formal requirement or 'other' there was quite often an expectation or culture of collaboration.

Regarding the different types of support that the public health team offered, there was a reasonable consensus between what DsPH felt they were offering across the authority and what support elected members felt was available to them. Provision of population and health data headed the list of support that was available and actively used, followed by needs assessment analysis, support and

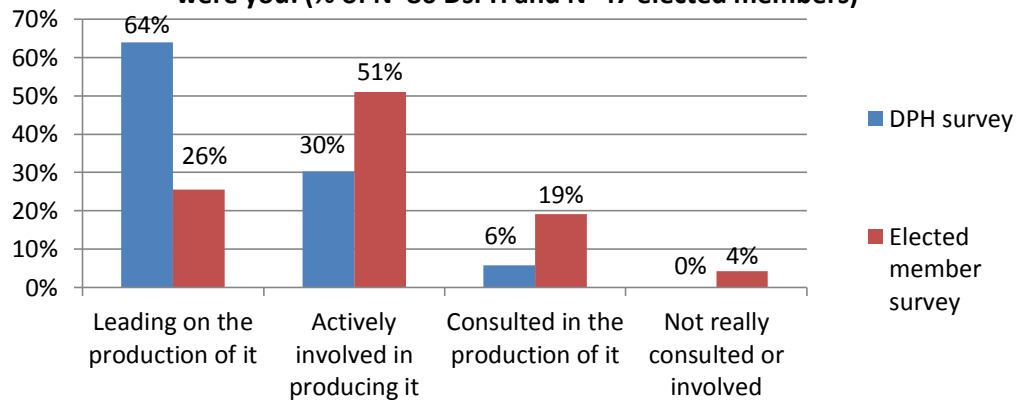
advice for commissioning, monitoring health against goals or targets, and inequalities analyses (DQ24, EQ11 and figure 14).

Figure 14: What support do you/ the public health team offer to others/ elected members in your local authority? (% 'yes - and actively used' of N=86 DsPH and N=48 elected members)



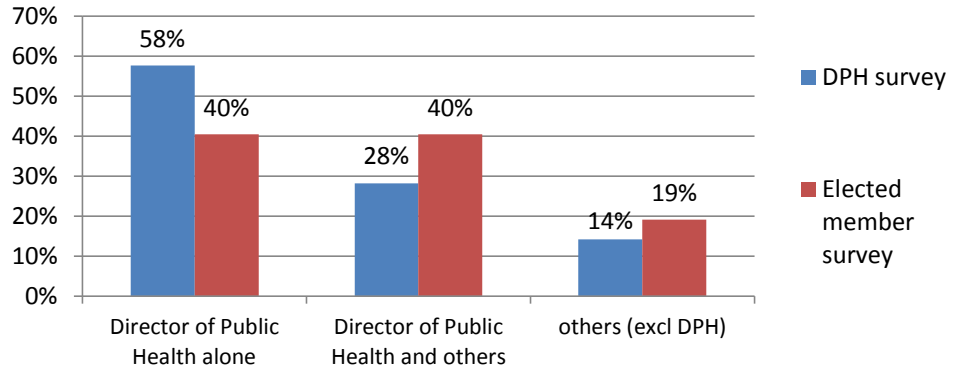
It was usual for DsPH to be either leading on (64%) or actively involved in (30%) the production of the Joint Health and Wellbeing Strategy locally. Elected members also played a considerable part with 26% leading and 51% being actively involved in preparing the strategy (DQ25, EQ12 and figure 15).

Figure 15: For your area's latest Joint Health and Wellbeing Strategy, were you: (% of N=86 DsPH and N=47 elected members)



In most cases DsPH said they authorised how the ring-fenced budget was spent, either alone (58%) or with others (28%), while the view of elected members was that this responsibility was more often shared. When the DPH could not authorise expenditure it was signed off by the cabinet, the Director of Finance or other directors or members depending on levels of expenditure and the directorate in which public health was located (DQ27, EQ14 and figure 16).

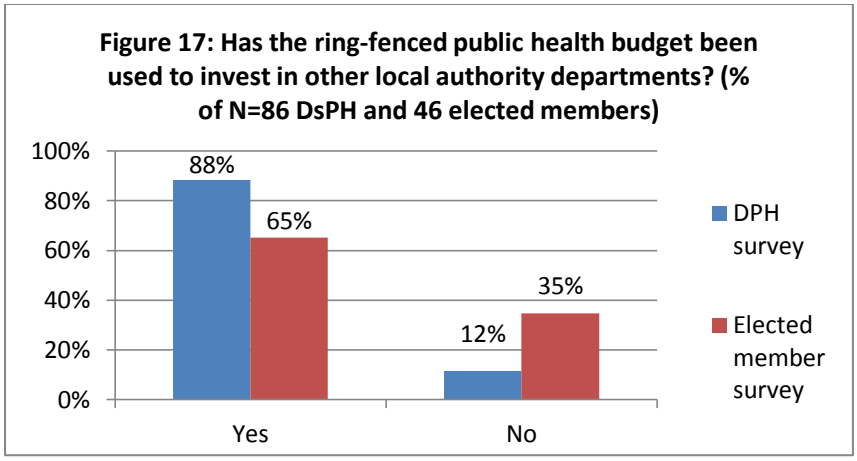
Figure 16: Who authorises expenditure from the ring-fenced public health budget? (% of N=85 DsPH and N=47 elected members)



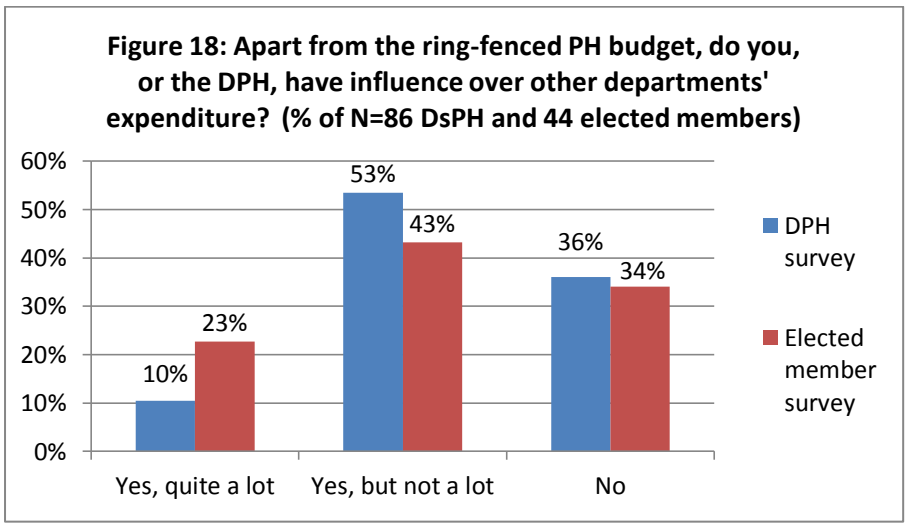
DsPH who were on the most senior corporate management team were more likely to have this authority (p=0.015). There was some variation in this aspect of DsPH' power for authorities with distinct public health directorates, those where public health was part of another directorate and those where the public health team was merged/distributed/other, but it was not statistically significant.

The view of DsPH was that the last public health business plan had either been 'approved without change' (76%) or was 'approved with minor changes' (24%). When elected members were asked about the level of discussion and debate over the public health business plan, their replies suggested a greater level of debate, as they were evenly divided between saying the business plan was 'discussed and debated extensively' or 'discussed and debated briefly' (DQ28, EQ15).

DsPH were asked if additional funds had been made available to public health. 19% said this was the case - for example, additional funds to cover new responsibilities/staff, or from the CCG for specific programmes (DQ29). Both surveys asked if the public health ring-fenced budget had been used to invest in other local authority departments. More DsPH (88%) than elected members (65%) thought that this was the case (DQ30, EQ16 and figure 17). The comments gave a wide range of examples of these investments, and also showed that DsPH were not always in favour of them. When expenditure was consistent with health priorities or could be agreed using set criteria (for example it contributed to public health outcomes or was based on evidence), DsPH were supportive and even proposed such expenditure. However a few examples were given where DsPH said they did not support expenditure, such as transfer to general funds or to allow other services to make savings, and there were other uses of the ring-fenced budget that DsPH did not fully support if they were unlikely to lead to improvements in public health. The comments of elected members showed them to be clear that such expenditure of the ring-fenced budget had to be accompanied by a convincing argument for a health benefit.



While just over a third (36%) of DsPH felt they had no influence over other departments' expenditure, 53% said 'yes, but not a lot' and 10% said 'yes, quite a lot', and the comments indicated that DPH's new responsibilities and membership of cross departmental or corporate groups was an enabling factor. Elected members were more likely to say that DsPH had a lot of influence (23%). See DQ31, EQ17 and figure 18.

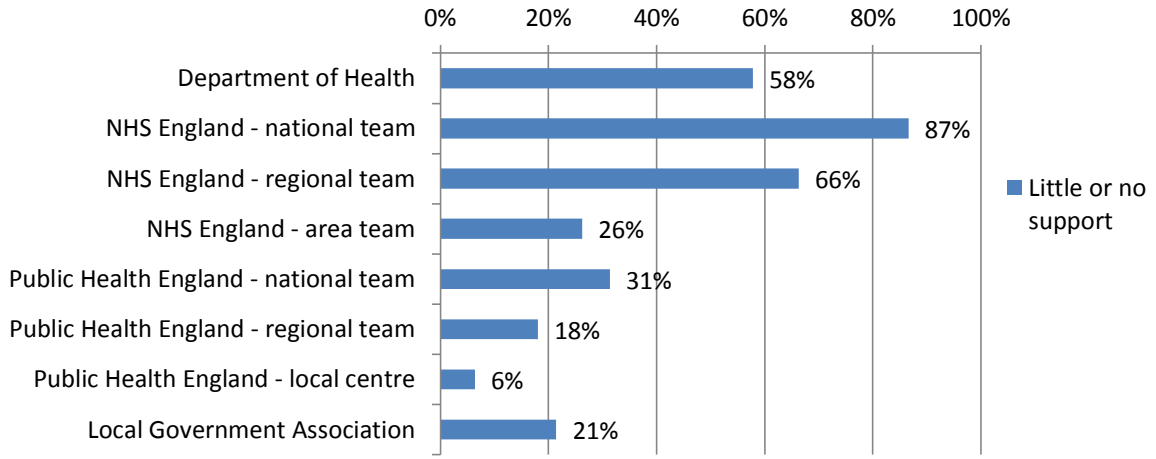


3.4 Relationships with external organisations

Full details of responses to questions about relationships with external organisations are provided in the frequency tables for DQ32-35, and, EQ18-21 in Appendix 1.

The surveys asked what support had been received from the Department of Health (DH), NHS England (NHSE), Public Health England (PHE), Local Government Association (LGA) and others. Many DsPH had received 'excellent support' (19%) or 'a good level of support' (53%) from their PHE local centre, and 23%-25% had received 'a good level of support' or 'excellent support' from the LGA or the PHE regional team. DsPH said they had also received varying levels of support from the Association of Directors of Public Health (ADPH) and other DPH networks. While some support had been received from the other organisations we asked about, high proportions of DsPH said they had got 'little or no support' (DQ32 and figure 19).

Figure 19: Since the April 2013 reforms, how much support (eg advice or guidance) have you received from: (% of N=83 DsPH) saying 'little or no support'



Elected members were asked a similar but less detailed set of questions. Over half said they had received 'a good level' or 'excellent' support from LGA (62%) and PHE (54%). Elected members had received less support from DH and NHSE with most saying they had received 'some' support from DH (71%) and NHSE (59%) (EQ18).

Relating to specific areas of help from PHE to improve health, the survey asked if DsPH and elected members got support from PHE in the following ways: generating and sharing data; synthesising knowledge and evidence of effective interventions; providing professional and scientific expertise; helping to develop the public health system and its specialist workforce; and providing encouragement with discussions and supporting action. Most DsPH said 'yes to some extent' (60%-81%), a few said 'yes fully' (5%-21%), and some said 'no or not really' (6%-20%), rising to over a third (35%) saying 'no or not really' when asked if PHE had supported them in developing the public health system and its specialist workforce (DQ33). Compared to DsPH, more elected members (7%-43%) ticked the response 'no or not really' when asked if they had received support from PHE. Elected members were most positive about PHE supporting them by generating and sharing information, followed by synthesising knowledge and evidence of effective interventions (EQ19).

Comments in the DPH survey about the value added by PHE showed that it was often focused on health protection which it did well. The local centres had acted as a point of contact and had been suppliers of information, but the support for health improvement was often described as limited, the centres were seen as under-funded and disappointingly slow to get started (DQ34). While some elected members were positive about their PHE local centre, they also mostly considered them to have had low impact (EQ20). When asked what support was wanted and from whom, there was a plethora of suggestions including wanting PHE to be more active, focused and visible, wanting better access to data, more local data, more practical support, help with health economic modelling, evidence reviews, strategic direction, accountability in the system, as well as better human resources and workforce development (DQ35). Elected members also mentioned the need for local and shared data, and while they wanted some support, they also wanted less top-down bureaucracy, more per capita funding and freedom to make local decision-making (EQ21).

3.5 Role of the health and wellbeing board

Full details of responses to questions about the health and wellbeing board are provided in the frequency tables for DQ36-38 and EQ22-24 in Appendix 1.

The surveys were completed by people who were members of the Health and Wellbeing Board (HWB) – 97% in the DsPH survey and 98% in the elected member survey (DQ36, EQ22).

When asked their opinion on how well the HWB was performing in a number of areas, elected members leading on health were much more positive than DsPH about all aspects (DQ37, EQ23 and table 2 below). For example, on whether the HWB was identifying the main health and wellbeing priorities, 86% elected members said 'definitely' compared to 61% of DsPH, and on strengthening relationships between commissioning organisations, 77% elected members said 'definitely' compared to 40% of DsPH. At the other end of the rankings, 35% of elected members compared to only 6% of the DsPH felt that the HWB was 'definitely' making difficult decisions.

Table 2: In your opinion is the Health and Wellbeing Board… (% of replies in DPH and elected member surveys)		Definitely	To some extent	Not really	N
Instrumental in identifying the main health and wellbeing priorities?	DPH	61	33	6	81
	Elected Member	86	14	0	43
Strengthening relationships between commissioning organisations?	DPH	40	52	9	81
	Elected Member	77	18	5	44
Beginning to address the wider determinants of health?	DPH	24	49	27	81
	Elected Member	59	36	5	44
Influencing cross-sector decisions and services to have positive impacts on health and wellbeing	DPH	15	64	21	81
	Elected Member	50	43	7	44
Facilitating the greater use of collective budgets?	DPH	12	56	32	81
	Elected Member	43	50	7	44
Helping to foster a collective responsibility for the use of budgets?	DPH	10	63	27	81
	Elected Member	41	46	14	44
Successfully incorporating active citizen involvement?	DPH	10	42	48	81
	Elected Member	16	68	16	44
Making difficult decisions?	DPH	6	31	63	81
	Elected Member	35	51	14	43
Directly commissioning services?	DPH	1	11	88	81
	Elected Member	16	37	47	43

Asked how they saw their role on the HWB (DQ38, EQ24), two thirds or more of DsPH felt that membership of the HWB was enabling - for example it allowed them to influence decision-making in other organisations locally (67%), and strategically influence work in the local health/social economy (77%). Responses from elected members were fairly similar, but slightly more positive, saying that membership of the HWB allowed them to influence decision-making in the authority (83%) and engage with the development of the Better Care Fund (83%). The views on this issue from both DsPH and elected members were more equivocal - for example, that policy developments were not necessarily due to the HWB; that it was still early days for HWBs; there was some frustration that they lacked authority; and some were not functioning or focusing well on various issues.

3.6 Support given to clinical commissioning groups

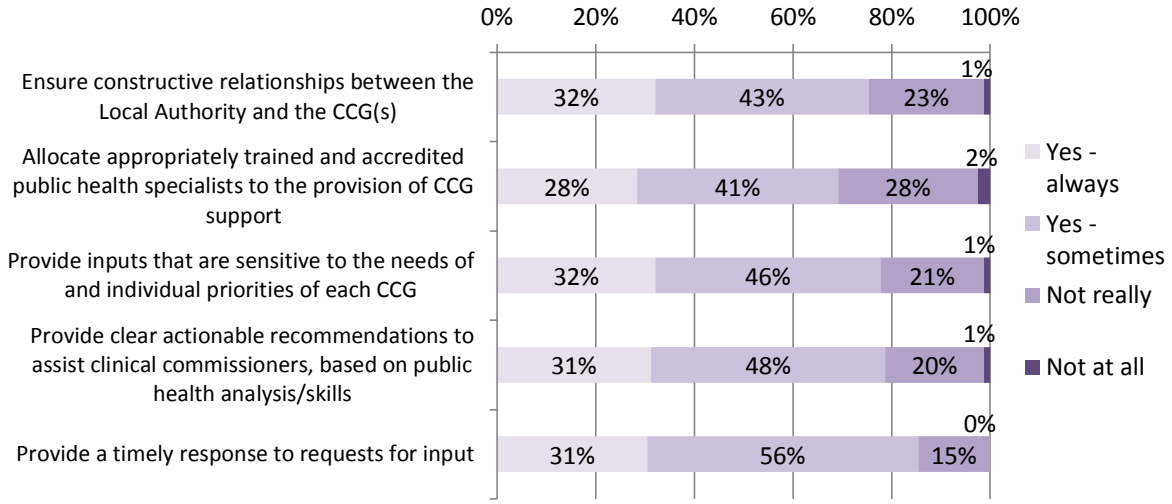
Full details of responses to questions about the support given to clinical commissioning groups are provided in the frequency tables for DQ39-41 in Appendix 1.

These questions only appeared in the DPH survey. The number of clinical commissioning groups (CCGs) in local authorities responding to the survey ranged from 1 to 7. Whilst a single CCG was the most usual (73%), 18% had 2-3 CCGs and 9% had 4 or more. The survey asked which of a number of services had been provided to CCGs in the previous 12 months by the public health team, and whether the capacity of the public health team was sufficient in specific areas.

All DsPH said they had provided help with strategic planning and assessing needs (100%), and high proportions had also provided help with reviewing service provision (88%) and deciding priorities (85%). Somewhat fewer had helped with monitoring and evaluation (73%) and procuring services (40%), although DsPH in two-tier authorities were more likely to say that in the last year they had helped CCGs with procuring services (63% of 2-tier compared to 33% of unitary authorities, ($p=0.029$). A few DsPH (8%) said they had provided 'other' services, such as infection control, to CCGs in addition to the ones they are required to (DQ40).

Between 28%-32% said the public health team could 'always' provide the support to CCGs that the April 2013 re-structuring expected of them, and 41%-56% said public health had sufficient capacity but only 'sometimes'. Finally, between 15% and 31% said that their capacity was 'not really' or 'not at all' sufficient to be able to carry out these duties (DQ41 and figure 20).

Figure 20: Is the capacity of the public health team sufficient to be able to: (% of N=81 DsPH)



Capacity varied according to the type of authority and whether one or many CCGs were being supported. In London boroughs, where there was only one CCG to support, only 13% of DsPH said that their public health team 'always' had sufficient capacity to ensure constructive relationships, allocate appropriately trained staff, provide actionable recommendations and timely responses to CCGs (not statistically significantly different), whereas non-London unitary authorities did not stand out from the averages in Fig 20). In contrast, 57% of DsPH working with four or more CCGs felt there was 'always' sufficient capacity in these areas (not statistically significant as only seven DsPH were working with so many CCGs), and in two-tier authorities there was 'always' capacity in all but the last area of support. This result is slightly counter-intuitive as it showed that DsPH in county councils with many CCGs to support felt more able to do so than London boroughs with only one associated CCG. DsPH' comments highlighted some of the capacity problems of public health teams, including a loss of staff and difficulties filling vacancies; therefore they had to manage their work programmes carefully, and this did not always fit well with CCG requests and timescales.

3.7 Emerging changes to commissioning and approaches to improving health

Full details of responses to questions about changes to commissioning and approaches to improving health are provided in the frequency tables for DQ42-44 and EQ25 in Appendix 1.

DsPH were asked about changes that had been made in commissioning under the public health budget, and elected members were asked a more general question about their authority's approach to improving health.

The great majority of DsPH (94%) said they had made changes to services directed at health improvement and commissioned under the public health ring-fenced budget in the 16 month period since the reforms. Many were involved in re-designing services (87%), and well over a half had set up new services (69%), changed provider (68%), and even de-commissioned services (58%, DQ42). DsPH said that the changes were across many services and health improvement areas, but

predominantly in the areas of sexual health, drugs and alcohol, followed by weight management, smoking and exercise. One DPH said that all (hundreds) of their contracts had been re-tendered or re-shaped, and another said they were halfway through reviewing all their contracts.

Some more detailed work has been done on changes – see section 3.9 and Jenkins et al (2015).

Regarding commissioning arrangements for one important aspect of health improvement (obesity and weight management), there had been somewhat less change, with 41% reporting no change, 34% having commissioned new services, 15% having de-commissioned services, and 16% having made other changes to services aimed at reducing obesity. The comments provided more detail on the variety of changes: these included some reductions in tiers 3 and 4 especially if they were ineffective or not NICE compliant; some increases in tiers 1 and 2; a range of service reviews and re-designs (DQ44).

Elected members were asked if they would like to see changes in the way their authority went about improving health of the local population. There was a fairly equal split between those who said 'yes, I would like to see us change' (45%) and those who said 'no, I think we have got it about right' (55%, EQ25). Comments on this suggested the change elected members would like to see was more integrated working, thinking and decision-making, both within the authority and beyond, and greater power and responsibility given to public health.

Elected members were also asked to give their authority's three main activities specifically about preventing obesity and improving weight management in their area. This gave a long list of healthy eating and exercise programmes, quite often targeting children, schools or leisure centres, and other healthy lifestyle promotions.

3.8 Comparison of DPH and elected member responses

This section describes the different perspectives in the 34 councils where both DPH and the elected member leading on health responded - a number that was smaller than anticipated, considering we had replies from 115 authorities.

Results from the small sample tended to repeat and were not statistically significantly different from the overall figures already given. For example, the authorities with two replies confirmed the relative grades and experience of DsPH and elected members with the health portfolio. They confirmed it was not unusual for both to sit on a number of relevant cross-departmental groups (in 68% of authorities both sat on the committee for older people, and in 50% both were on the committee for corporate strategy), and that elected members were often actively involved in the production of the Joint Health and Wellbeing Strategy. The two perspectives confirmed, for example that the public health team had gained in their ability to have influence across the local authority and elected members gained in their ability to influence CCGs.

Further to confirming results already seen, the 34 responses were also able to show how far DsPH and elected members working in the same authority shared the same view on topics. For example, they tended to agree on the extent to which public health staff had built good relationships within the authority (71% gave the same answer), but only 42% gave the same answer when asked if public

health staff were valued across the authority. There was some variation in views of what support the public health team offered and how well it was used, with greater agreement on the provision of population data, needs assessment data and support for commissioning, and less agreement on the supply and use of monitoring data and inequalities analyses.

There was disagreement in nearly half the authorities on who was responsible for authorising the ring-fenced public health budget, but 69% agreed on whether the ring-fenced public health budget had been used to invest in other departments. When asked if the DPH had influence on expenditure over and above the ring-fenced budget, there was agreement in only 36% of the authorities giving a dual perspective. However, although many different responses have been noted between the DPH and their corresponding elected member, these were often differences between choosing to tick a reply like 'yes all the time' over 'yes to some extent', and so the lack of agreement in replies may often be due to modest differences in the use of language rather than reflecting large differences in perceptions

There was also some disagreement on the level of support from Public Health England, but this may be an accurate reflection of the situation for DsPH compared to elected members. With regard to HWBs there was most agreement about the board being instrumental in identifying the main health and wellbeing priorities, and least agreement on the HWB having made difficult decisions, having begun to address the wider determinants of health, and having influenced cross-sector decision and services impacting on health and wellbeing.

3.9 Additional analyses - statistical associations and differences

Further to the findings given above, a number of cross-tabulations and tests of association were undertaken using the DPH survey data as there were insufficient responses from elected members to provide useful analyses of this type. These were to explore questions such as: did the experience of DsPH and elected members vary for different types of authority; what factors were associated with local authorities having made changes in the way the public health budget was spent, or with DsPH who felt the reforms had given them greater influence.

3.9.1 Changes in commissioning

Changes to commissioning were more common in authorities where the DsPH felt they were 'always' or 'quite often' able to influence the priorities of their authority, compared to those 'not often' or 'never' able. For example, these authorities were twice as likely to have set up new services (77% compared to 38%, p=0.005) or to have changed the provider of an existing service (76% compared to 38%, p=0,006).

There was a statistically significant association indicating that there were more reports (76% compared to 56%, chi-square = 5.7, df=1, p=0.017) of de-commissioning services in areas with greatest material deprivation. This was the only association found between local authority characteristics and changes in commissioning.

Some changes were happening more often with particular organisational circumstances. For example, where there was a requirement for other departments to collaborate with public health on

their plans, it was more likely for new services to be set up (84% compared to 68%, chi-square = 11.8, df=2, p=0.003). Also, where the HWB was 'definitely' instrumental in identifying health priorities, it was more likely that new services had been set up (85% compared to 68%, chi-square = 13.6, df=2, p=0.001), and that providers of existing services had been changed (79% compared to 68%, chi-square = 6.8, df=2, p=0.033). It should be noted that many tests of association between change and other variables were carried out and that the number of significant results was in line with what would be expected due to chance. Service re-design and starting the re-tendering process were both more common for DsPH with more years' experience in their post or in their authority, suggesting stability of leadership within public health is an important factor (statistical tests not used due to small numbers).

3.9.2 Perceived influence

There were statistically significant associations between the responses to some of the questions about influence. DsPH who, since the reforms, 'always' felt able to influence priorities within their authority (Q21) also felt: more able to influence the work of the local authority (Q22ii, chi-square = 48.3, df=2, p=0.000); they had influence over other department's expenditure (Q31, chi-square = 15.7, df=4, p=0.003); that being on the HWB allowed them to influence decision-making in their own organisation (Q38i, chi-square = 5.9, df=2, p=0.053). There was also an association between influence in the authority (Q21) and feeling able to deliver real health improvements in other areas like workplaces and schools (Q22iv, chi-square = 6.0, df=2, p=0.050).

We looked for other factors associated with influence, such as how the public health team was organised and operated within the local authority and how the HWB was functioning. The strongest statistical association with influence was found when public health teams had built good relationships within their authority. DsPH who were managed by the council's Chief Executive were also more likely to say they were always able to influence priorities within the local authority (23% compared to the average of 15%). Similarly, where respondents felt they had little influence, they also felt that the public health team was not really being valued, not being asked for advice, or the information they supplied was not really being trusted. Respondents' abilities to influence local authority priorities were also associated with a requirement by other departments to collaborate with public health on their plans, with HWBs being clearly instrumental in identifying health priorities, and the council's cabinet engaging in the process of approving public health business plans.

3.9.3 Perceived influence of public health compared to local authority characteristics

This section examines whether the views on influence varied according to characteristics of the authority where DsPH were based, such as the type of authority, the political party in power, the number of residents and the size of the public health budget. There were slightly more statistically significant associations at the 95% confidence level than would be expected by chance. For example, there were local factors associated with feeling able to influence priorities within the local authority (Q21), and whether being on the HWB allowed DsPH to have influence more widely in the local economy (Q38ii, Q38iii). Specifically, while 15% of DsPH felt they were always able to influence the priorities in their authority, this fell to 4% in areas with greatest material deprivation. Although DsPH had been positive about membership of the HWB with 64-74% saying it enabled them to be influential in decision-making in various ways, there were situations where membership of the HWB

had a lesser effect. For example, in London boroughs (17 responses) compared to other types of councils, 59% of DsPH said that being on the HWB allowed them to strategically influence work in the local health/social economy compared to the average of 74% (chi-square = 8.9, df=3, p=0.030). In Conservative-led councils (25 responses), a lower percentage of DsPH said that being on the HWB allowed them to influence decision-making in other organisations locally (48% compared to the average of 66%, chi-square = 7.2, df=2, p=0.027).

The experience in two-tier authorities was compared to that in unitary authorities. There were some indications of variation; 88% of respondents in two-tier authorities compared to 57% of those in unitary authorities said they had influence over other departments' expenditure (chi-square = 5.4, df=2, p=0.067). They felt more able to influence the wider economy and had made commissioning changes, but the number of two-tier authorities in the survey was small (N=17), and none of these differences were statistically significantly different from the experience in unitary authorities.

3.10 Summary of DPH and elected member survey responses.

Most of the respondents in the DPH survey (92%) were directors or acting directors of public health, and in the elected member survey 93% were cabinet members holding the health portfolio. Survey respondents were also experienced in their role, as most in the DPH survey had worked 5 years or longer at their level/grade, and elected members had served a similar length of time in their local authority. Nevertheless, within local government there was a mis-match of status and standing as over a quarter (29%) of respondents to the DPH survey were acting up/ interim directors or had less than a year's experience of working in the local authority.

Nearly a third of local authorities had found it advantageous to set up formal sharing arrangements with other authorities such as having a shared DPH or a single public health team, or a core team as well as the teams in each authority. In addition to these permanent arrangements, around half the DPH survey respondents had informal alliances, networks and collaborations with other authorities which they found to be helpful.

The most usual arrangement of public health after the re-structuring was to be a section in another directorate, and these ranged from corporate strategy to neighbourhoods and from commissioning to housing, but more usually public health was located in the directorate for adult services or health and wellbeing. In over a quarter of authorities public health had been set up in a directorate by itself. In the transfer there had been some loss of public health staff, including directors, consultants, specialists and others, although there were also some gains particularly for other staff, and the new arrangements had led to changes in the DsPH' responsibilities.

With regard to the new relationships, DsPH seemed to be enjoying good and unfettered lines of communication with elected members and also reported good access to the leader and cabinet members. DsPH and elected members were positive about the progress public health staff had made in building good relationships within the authority with 79% DsPH compared to 70% elected members saying this had definitely happened, although DsPH were less positive than elected members in how much they felt that PH staff were valued across the authority (42% of DsPH compared to 53% of elected members said 'yes - definitely'.

Factors associated with a successful transfer of public health were seen to be about people, relationships and having competent organisational arrangements. DsPH attributed success to high quality staff and leadership, and elected members to having a smooth transition and building good relationships. While DsPH saw budget cuts as a major barrier, elected members saw the incoming public health budget as an enabling factor, and they welcomed the arrival of new money for the authority to spend. Both thought that cultural differences were a barrier, especially when accompanied with a reluctance to change, and there were mixed feelings about the extent to which public health was understood.

Compared to elected members with responsibility for health / public health, DsPH were more likely to be sitting on cross-departmental groups and committees, such as youth/young people, environment/sustainability, and regeneration/economic development. The authorities where we had two replies confirmed that it was not unusual for both the DPH and the elected member with the health portfolio to sit on cross-departmental groups.

Over half the respondents in both surveys felt 'quite often' able to influence the authority's priorities in respect of improving health, and a considerable proportion of elected members (40%) said they were 'always' able to do this. Since the reforms both felt their influence had changed and that they were more able to deliver real improvements in local health. In particular, a large proportion of DsPH felt more able to have an impact across their authority compared to elected members (82% compared to 67%), elected members felt more able to deliver improvements by influencing CCGs, and both felt they had gained in being more able to influence the work of other organisations, such as workplaces and schools. The increase of public health's influence within the authority was likely to have been helped in so far as over half of the local authorities in the survey said there was a requirement for other departments to collaborate with public health on their plans.

There was similarity in the two perspectives on the support the public health team offered and whether it was being actively used, apart from needs assessment analysis, where more DsPH (84%) compared to elected members (70%) saying this service was well used. While the DPH and their team were much more likely to lead the production of the Joint Health and Wellbeing Strategy, it was clear that elected members were often actively involved, and this difference was confirmed in the authorities where we had replies from both surveys.

There was some disagreement on who was responsible for authorising the ring-fenced public health budget. 58% of DsPH said it was them alone, and 40% of elected members said it was the DPH alone. Equally divergent was the view of whether the budget had been used to invest in other departments with 88% of DsPH compared to 65% of elected members saying this had occurred. When asked if the DPH had influence on expenditure over and above the ring-fenced budget, more elected members than DsPH (23% compared to 10%) felt the DPH had 'quite a lot' of influence over other departments' expenditure. All DsPH said that their latest business plan had been passed with nothing more than minor changes, and 76% said it had been approved without any changes, even though the view of elected members was that there was often extensive debate of public health's business plan. All these results were confirmed in the authorities where we had a dual perspective. Some DsPH had received additional funds to the ring-fenced public health budget, for example, when public health had been given additional responsibilities within their authority or were running CCG-funded programmes.

Compared to DsPH, elected members felt they had received a greater level of support from DH, NHSE, PHE and the LGA. To compensate for this, DsPH had the support of the Association of Directors of Public Health and other professional networks. DsPH' overall lower ratings of the level of support received may be a reflection of the degree to which DsPH and elected members looked to and expected support from other organisations, in particular the DH, NHSE and PHE. Comments in both surveys showed dissatisfaction with levels of support from PHE, and a demand for a more enabling approach from above.

Almost all survey respondents were members of their HWB. As discussed earlier, elected members were once again more positive about how well the new arrangements were working. With regards the overall effectiveness of the HWBs, elected members were much more likely than DsPH to say it was 'definitely' performing in all aspects of the HWB . They rated most highly: strengthening relationships between commissioning organisations (77% compared to 40% DsPH said 'definitely') and identifying the main health and wellbeing priorities (86% compared to 61% DsPH said 'definitely'). Elected members were also much less likely than DsPH to say the HWB was 'not really' performing in all the areas asked about. For example, substantial proportions of DsPH thought the HWB was not really making difficult decisions, not really facilitating the greater use of collective budgets, not really addressing the wider determinants of health, and not really influencing cross-sector decisions with positive impacts on health. When asked about their own role on the HWB and what membership allowed them to achieve, DsPH and elected members felt that being on the board enhanced their influence in a number of areas.

Public health teams had varied responsibilities in relation to the number of CCGs they supported. The range of services they offered were well used, although providing help with procuring services was more likely to be happening in two-tier authorities. There were, however, issues about the capacity of the public health team to provide the required levels of support to CCGs; about a third of public health teams could always do this, about half could only do so some of the time and around a quarter were not really able to provide the required help to CCGs. While DsPH said they had the capability, they were short of staff to meet the needs of CCGs.

Changes made to commissioning under the public health ring-fenced budget were widespread by the time of the survey (summer 2014), with nearly all authorities replying to our survey saying that they had made some changes, these included setting up new services and de-commissioning services that were in existence in April 2013.

4 Discussion of findings

4.1 Strengths and weaknesses of the surveys and their results

The online surveys to upper tier and unitary authorities in England achieved a good quantity and quality of responses. Although fewer councillors than directors of public health completed their questionnaires, response rates were good compared to similar studies (ADPH 2014; Jongsma 2014), and were representative of the whole of England in terms of geographical spread, type of authority, political party control, population size and public health budget allocated per head.

The results have been presented here as the distribution of responses to each question and a summary of what was contained in the comments. Comparisons have been made where possible between the responses from DsPH and elected members, and these have been checked using the sample of authorities where replies were received from both perspectives. Some additional analyses have been presented as cross tabulations and tests of association between two variables. Given the relatively small numbers of survey responses, tests can only detect large differences as statistically significant, and using the 95% confidence level in a large number of tests of association will inevitably throw up some spurious or 'chance' results.

4.2 Concluding remarks

Despite the turbulence of the reforms that had brought them together, both public health leaders and elected members leading on health / public health seemed very positive by the time of the surveys (summer 2014). Elected members were inevitably more experienced within local government, and given the changes, some public health teams were being led by acting or interim directors. However it was not obvious that these differences in position and status were problematic. The location of and arrangements for public health varied, with the majority being placed in a larger directorate, such as adult services, and quite a few others remaining as a distinct public health directorate. It is not clear which arrangement works better, as the potential benefits of the former were to have an immediate chance to be embedded into local government, and the benefits of the latter were to have a degree of autonomy and the DPH usually having a direct reporting line to the Chief Executive. Some differences in responsibilities and budgets flowed from these arrangements, and some differences were seen between different types of authorities. For example, when former public health responsibilities became shared after the re-structuring, DsPH could lose some control over public health funds. We also noticed that public health teams in two-tier authorities felt more able to influence and make changes, and that those in London boroughs saw less benefit from membership of the HWB compared to the national picture.

The survey results overall suggested that the transition had gone well, that public health had been welcomed and that their skills and services had been valued and used within the authority. In remarks made at the end of the survey by some DsPH, the general view was that the move to local authorities had been difficult but had provided public health with new opportunities. However, these DsPH also had considerable concerns for the future, for example about the pressure on public health budgets when no longer ring-fenced, and that changes in pay and conditions would not make public health a sufficiently attractive career to be sure of retaining a high quality and professional work force. Successful integration was helped by a number of factors, such as high quality leadership, strong organisational arrangements and clear lines of reporting, shared goals and public health actually delivering good quality work. Elected members felt there was a mutual respect between themselves and DsPH, and they welcomed the funding that came with public health. On the negative side, the DsPH that felt less influential also felt the services the public health team provided were not well used. Clearly the move was not helped by occurring at a time of massive budget cuts in local government, and both DsPH and elected members cited the historically different cultures and ways of working that made successful integration of public health more challenging.

Perhaps it is not surprising that the shift of public health teams to local authorities was accompanied by changes in their relationships with the NHS. DsPH continued to provide a well-used service to CCGs, but the survey indicated that they often felt under-staffed to meet the needs of CCGs. DsPH also felt poorly supported by national and regional organisations such as the Department of Health, NHS England and PHE, a perception echoed by elected members who felt they had received little help apart from that provided by the Local Government Association.

Both DsPH and elected members welcomed the widening of their influence following the reforms, for example with DsPH sitting on a number of cross-departmental committees, and elected members having access to CCGs from their membership of the HWB. DsPH were rather more sceptical than elected members about what the HWB was achieving, but they were both very positive that sitting on the HWB enhanced their influence. DsPH had good access to elected members and could see fresh opportunities to influence neighbourhoods and communities.

With regard to control over public health spending, DsPH felt they largely had control but in reality this was often subject to council rules over authorising expenditure or subject to cabinet ratification. Nevertheless many reported changes such as new, re-designed, or de-commissioned services under the ring-fenced public health budget. After a slow start, by summer 2014 there seemed to have been many changes in commissioning for health improvement, although we do not know how substantial these changes were. Changes were more likely in authorities where DsPH and HWBs were having an impact or where there was a culture of collaboration with other local authority departments.

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Appendix 1: Frequencies and cross tabulations of responses (all questions)

DQ refers to the DPH survey question number, EQ refers to the elected member survey. Similar questions are placed together to enable comparisons, e.g. DQ6 is followed by EQ3, or put in the same table, e.g. DQ20 and EQ7.

DQ1 Does your public health team deliver part (or all) of a service that is shared between multiple upper-tier/unitary authorities?

		Frequency	Valid Percent
Valid	Yes	31	32.3
	No [skips past next three questions]	65	67.7
	Total	96	100.0

DQ2 Please state number

		Frequency	Valid Percent
Valid	0	1	3.4
	2	15	51.7
	3	5	17.2
	4	1	3.4
	5	2	6.9
	6	4	13.8
	11	1	3.4
	Total	29	100.0

DQ3 Is the sharing arrangement intended only to be temporary? (i.e. covering a vacant position)

		Frequency	Valid Percent
Valid	Yes, for a temporary period only	1	3.6
	No, it will continue	27	96.4
	Total	28	100.0

DQ4 What is the nature of the sharing arrangement? (please tick one box)

		Frequency	Valid Percent
Valid	Shared Director of Public Health (DPH) with distinct teams in each local authority	7	25.0
	Shared 'core' team in addition to distinct teams in each local authority	6	21.4
	Single shared team working across all participating local authorities	7	25.0
	Other (please explain):	8	28.6
	Total	28	100.0

DQ5/EQ1 Name of local authority

DQ6.1 In the authority named in the drop-down box above -

		Frequency	Valid Percent
Valid	Less than 6 months	8	8.7
	6 - 11 months	13	14.1
	12 - 23 months	42	45.7
	2 - 4 years	10	10.9
	5 years or more	19	20.7
	Total	92	100.0

DQ6.2 In total at this level/grade (NHS or local government) -

		Frequency	Valid Percent
Valid	Less than 6 months	2	2.3
	6 - 11 months	6	7.0
	12 - 23 months	14	16.3
	2 - 4 years	11	12.8
	5 years or more	53	61.6
	Total	86	100.0

EQ3.1 In the authority named in the drop-down box above -

		Frequency	Valid Percent
Valid	12 - 23 months	2	3.9
	2 - 4 years	11	21.6
	5 years or more	38	74.5
	Total	51	100.0

EQ3.2 As a cabinet / executive member in the authority named above -

		Frequency	Valid Percent
Valid	Less than 6 months	1	2.0
	6 - 11 months	2	4.0
	12 - 23 months	8	16.0
	2 - 4 years	21	42.0
	5 years or more	18	36.0
	Total	50	100.0

EQ3.3 As 'health' portfolio holder in the named authority -

		Frequency	Valid Percent
Valid	Less than 6 months	3	5.9
	6 - 11 months	2	3.9
	12 - 23 months	19	37.3
	2 - 4 years	18	35.3
	5 years or more	9	17.6
	Total	51	100.0

DQ7 What is your role? (please tick one box)

		Frequency	Valid Percent
Valid	Director of Public Health (DPH)	79	84.9
	Consultant in Public Health	2	2.2
	Other	5	5.4
	Acting / Interim DPH	7	7.5
	Total	93	100.0

EQ2 Are you a member of the Council's Cabinet / Executive? (please tick one box)

		Frequency	Valid Percent
Valid	Yes	50	92.6
	No	4	7.4
	Total	54	100.0

DQ6.1&7 Grade and experience (DPH)

	Frequency	Valid Percent
DPH or higher with 1+ year's experience in LA	66	71.0
Acting/ interim/ less senior grade or DPH with <1yr in LA	27	29.0
Total	93	100.0

EQ2&3.1 Grade and experience (Elected member)

		Frequency	Valid Percent
Valid	Cabinet/Exec member with 1+ year's experience in LA	49	96.1
	Not Cabinet/Exec member or with <1yr in LA	2	3.9
	Total	51	100.0

DQ8 In the transfer from NHS to local authority did the public health team change significantly in size or composition?

	Directors of Public Health	Consultants	Specialists	Others
Smaller	16.7%	29.2%	27.6%	31.9%
About the same	81.1%	58.4%	62.1%	47.2%
Larger	2.2%	12.4%	10.3%	20.8%

DQ9 How is your public health team arranged in this local authority? (please tick the option that best describes your arrangement, and give further details in the comment box)

		Frequency	Valid Percent
Valid	Our team is not based here - it is hosted by another local authority	3	3.3
	Our team is a distinct public health directorate in this local authority	25	27.8
	Our team is a section of another directorate (please specify)	46	51.1
	Our team is distributed across directorates or functions, or across multiple authorities (eg virtual, hub, etc)	5	5.6
	We have a merged model in which public health and another local authority directorate are combined	5	5.6
	Other (please give details below)	6	6.7
	Total	90	100.0

DQ10 Do you have any formal strategic alliances with public health teams in any other local authorities? (separate to joint/sharing arrangements, for example as in Cheshire and Merseyside where Public Health teams work together to enable greater access to publ

		Frequency	Valid Percent
Valid	Yes	48	53.3
	No	42	46.7
	Total	90	100.0

DQ11 To whom are you managerially responsible? (please tick one)

		Frequency	Valid Percent
Valid	Director of Public Health	3	3.3
	Local Authority Chief Executive	38	41.8
	Other	50	54.9
	Total	91	100.0

DQ12 Are you a standing member of your local authority's most senior corporate management team?

		Frequency	Valid Percent
Valid	Yes	50	54.9
	No	41	45.1
	Total	91	100.0

DQ13 Do you have direct access to elected members?

		Frequency	Valid Percent
Valid	Yes	88	98.9
	No	1	1.1
	Total	89	100.0

DQ14 To which elected members do you have direct access? (tick all that apply)

Portfolio Lead for Health	94.4%
Health and Wellbeing Board Chair	92.1%
Cabinet Members / Committee Chairs responsible for health	87.6%
Other	47.2%

DQ15 comment

DQ16.1 Does the DPH role cover all the core statutory responsibilities of DPHs in local authorities?

		Frequency	Valid Percent
Valid	Yes	84	98.8
	No	1	1.2
	Total	85	100.0

DQ16.2 Has the DPH gained additional local authority functions?

		Frequency	Valid Percent
Valid	Yes	30	35.7
	No	54	64.3
	Total	84	100.0

DQ16.3 Has the DPH handed over / lost some responsibilities to other parts of the local authority?

		Frequency	Valid Percent
Valid	Yes	20	25.3
	No	59	74.7
	Total	79	100.0

DQ16.4 Does the DPH now share some responsibilities with other parts of the local authority?

		Frequency	Valid Percent
Valid	Yes	33	40.7
	No	48	59.3
	Total	81	100.0

DQ17.1 Have public health staff built good relationships within the authority? (% of DsPH)

		Frequency	Valid Percent
Valid	Not really	2	2.3
	To some extent	16	18.6
	Yes - definitely	68	79.1
	Total	86	100.0

EQ4.1 Have public health staff built good relationships within the authority? (% of elected members)

		Frequency	Valid Percent
Valid	Not really	1	2.1
	To some extent	13	27.7
	Yes - definitely	33	70.2
	Total	47	100.0

DQ17.2 Are public health staff valued across the authority? (% of DsPH)

		Frequency	Valid Percent
Valid	Not really	8	9.5
	To some extent	41	48.8
	Yes - definitely	35	41.7
	Total	84	100.0

EQ4.2 Are public health staff valued across the authority? (% of elected members

		Frequency	Valid Percent
Valid	Not really	1	2.1
	To some extent	21	44.7
	Yes - definitely	25	53.2
	Total	47	100.0

DQ17.3 Do staff in other departments know what public health staff can offer? (% of DsPH)

	Frequency	Valid Percent
Not really	7	8.2
To some extent	66	77.6
Yes - definitely	12	14.1
Total	85	100

DQ17.4 Do staff in other departments ask for public health advice? (% of DsPH)

		Frequency	Valid Percent
Valid	Not really	3	3.5
	To some extent	42	48.8
	Yes - definitely	41	47.7
	Total	86	100.0

DQ17.5 Do staff in other departments trust public health advice? (% of DsPH)

		Frequency	Valid Percent
Valid	Not really	1	1.3
	To some extent	33	41.3
	Yes - definitely	46	57.5
	Total	80	100.0

DQ17 PH staff well integrated (4-5 replies in Q17 = yes definitely) (% of DsPH)

		Frequency	Valid Percent
Valid	well integrated	26	30.2
	less well integrated	60	69.8
	Total	86	100.0

DQ18-19, EQ5-6 – comments

DQ20/EQ7 Do members of the public health team sit on cross-departmental groups or committees focusing on the following areas? (tick all that apply) / EQ7 Within the local authority, do you sit on cross-departmental groups or committees focusing on the following areas? (tick all that apply)

	DPH survey	Elected member survey
Inequalities / social inclusion	65.1%	55.3%
Youth / young people	91.9%	38.3%
Older people	79.1%	74.5%
Regeneration / economic development	50.0%	25.5%
Environment / sustainability	65.1%	19.1%
Corporate strategy	65.1%	59.6%
Other	17.4%	19.1%

DQ21 To what extent do you feel able to influence the priorities of your local authority? (please tick one) (% of DsPH)

		Frequency	Valid Percent
Valid	Always able to influence priorities	13	15.1
	Quite often able	57	66.3
	Not often able	15	17.4
	Never able to influence priorities	1	1.2
	Total	86	100.0

EQ8 To what extent do you feel able to influence the priorities of your local authority, with respect to improving the local population's health? (please tick one) (% of elected members)

		Frequency	Valid Percent
Valid	Always able to influence priorities	19	40.4
	Quite often able	25	53.2
	Not often able	3	6.4
	Never able to influence priorities	0	0.0
	Total	47	100.0

EQ9 To what extent do you feel able to influence the priorities of your council's public health team in regard to public health? (please tick one) (% of elected members)

		Frequency	Valid Percent
Valid	Always able to influence priorities	20	42.6
	Quite often able	24	51.1
	Not often able	3	6.4
	Total	47	100.0

DQ22.1 To what extent do you feel able to deliver real improvements in local health by: (% of DsPH)

Re-prioritising what you do as a team?

		Frequency	Valid Percent
Valid	More so than before the reforms	46	54.1
	Similar to before the reforms	28	32.9
	Less so than before the reforms	11	12.9
	Total	85	100.0

EQ10.1 To what extent do you feel able to deliver real improvements in local health by: (% of elected members)

Influencing the work of the public health team?

		Frequency	Valid Percent
Valid	More so than before the reforms	42	89.4
	Similar to before the reforms	5	10.6
	Total	47	100.0

DQ22.2-4/EQ10.2-4 To what extent do you feel able to deliver real improvements in local health by:

DPH survey	**Influencing the work of the local authority as a whole?**	**Influencing the work of the local CCG(s)**	**Influencing the work of others (e.g. local workplaces, schools)**
More so than before the reforms	82.1	16.7	45.8
Similar to before the reforms	10.7	46.4	45.8
Less so than before the reforms	7.1	36.9	8.4

Elected member survey	**Influencing the work of the local authority as a whole?**	**Influencing the work of the local CCG(s)**	**Influencing the work of others (e.g. local workplaces, schools)**
More so than before the reforms	67.4	62.2	52.3
Similar to before the reforms	32.6	35.6	47.7
Less so than before the reforms	0	2.2	0

DQ23 Is there a requirement for other departments in your local authority to collaborate with Public Health on their plans? (please tick one)

	Frequency	Valid Percent
Yes - always	13	15.3
Yes - but only under certain circumstances	26	30.6

No	33	38.8
Other	13	15.3
Total	85	100.0

DQ24.1/EQ11.1 What support does the public health team offer to others in your local authority: Provision of population and health data

	DPH survey	Elected member survey
Yes, and actively used	88.4%	81.3%
Yes, but not actively used	9.3%	18.8%
Support not supplied	2.3%	10.4%

DQ24.2/EQ11.2 What support does the public health team offer to others in your local authority: Needs assessment analysis

	DPH survey	Elected member survey
Yes, and actively used	83.7%	69.6%
Yes, but not actively used	14.0%	28.3%
Support not supplied	2.3%	2.2%

DQ24.3/EQ11.3 What support does the public health team offer to others in your local authority: Monitoring health against goals or targets

	DPH survey	Elected member survey
Yes, and actively used	60.0%	66.7%
Yes, but not actively used	31.8%	31.3%
Support not supplied	8.2%	2.1%

DQ24.4/EQ11.4 What support does the public health team offer to others in your local authority: Inequalities analyses

	DPH survey	Elected member survey
Yes, and actively used	54.1%	60.9%
Yes, but not actively used	36.5%	34.8%
Support not supplied	9.4%	4.3%

DQ24.5/EQ11.5 What support does the public health team offer to others in your local authority: Support and advice for commissioning

	DPH survey	Elected member survey
Yes, and actively used	69.8%	76.7%
Yes, but not actively used	29.1%	18.6%
Support not supplied	1.2%	4.7%

DQ24.6/EQ11.6 What support does the public health team offer to others in your local authority: Other

	DPH survey	Elected member survey
Yes, and actively used	12.8%	8.3%
Yes, but not actively used	1.2%	0.0%
Support not supplied	0.0%	0.0%

DQ24/EQ11 What support do you/ the public health team offer to others/ elected members in your local authority? % saying 'Yes, and actively used

	DPH survey	Elected member survey
Provision of population and health data	88.4%	81.3%
Needs assessment analysis	83.7%	69.6%
Monitoring health against goals or targets	60.0%	66.7%
Inequalities analyses	54.1%	60.9%
Support and advice for commissioning	69.8%	76.7%
Other	12.8%	8.3%

DQ25/EQ12 For your area's latest Joint Health and Wellbeing Strategy, were you:

	DPH survey	Elected member survey
Leading on the production of it	64.0%	25.5%
Actively involved in producing it	30.2%	51.1%
Consulted in the production of it	5.8%	19.1%
Not really consulted or involved	0.0%	4.3%

DQ26/EQ13 - comments

DQ27/EQ14 Who authorises expenditure from the ring-fenced public health budget?

	DPH survey	Elected member survey
Director of Public Health alone	57.6%	40.4%
Director of Public Health and others	28.2%	40.4%
Others (excl DPH)	14.1%	19.1%

DQ28 When the last public health business plan was presented to the executive cabinet (or alternative), was it: (% of DsPH)

		Frequency	Valid Percent
Valid	Approved without change	42	76.4
	Approved with minor changes	13	23.6
	Total	55	100.0

EQ15 When the last public health business plan was presented to the executive cabinet (or alternative), was it: (% of elected members)

		Frequency	Valid Percent
Valid	Discussed and debated extensively	15	48.4
	Discussed and debated briefly	15	48.4
	Not discussed or debated	1	3.2
	Total	31	100.0

DQ29 Have additional funds to the ring-fenced budget been provided for the public health team's work?

		Frequency	Valid Percent
Valid	Yes	16	18.8
	No	69	81.2
	Total	85	100.0

DQ30/EQ16 Has the ring-fenced public health budget been used to invest in other local authority departments?

	DPH survey	Elected member survey
Yes	88.4%	65.2%
No	11.6%	34.8%

DQ31/EQ17 Apart from the ring-fenced PH budget, do you, or the DPH, have influence over other departments' expenditure?

		Frequency	Valid Percent
Valid	Yes, quite a lot	10	22.7
	Yes, but not a lot	19	43.2
	No	15	34.1
	Total	44	100.0

DQ32 Since the April 2013 reforms, how much support (eg advice or guidance) have you received from:

	Little or no support	Some support	A good level of support	Excellent support	N
Department of Health	57.8	41.0	1.2	0.0	83
NHS England - national team	86.6	13.4	0.0	0.0	82
NHS England - regional team	66.3	32.5	1.2	0.0	83
NHS England - area team	26.2	57.1	15.5	1.2	84
Public Health England - national team	31.3	55.4	10.8	2.4	83
Public Health England - regional team	18.1	59.0	19.3	3.6	83
Public Health England - local centre	6.4	21.8	52.6	19.2	78
Local Government Association	21.4	53.6	17.9	7.1	84

EQ18 Since the April 2013 reforms, how much support (eg advice or guidance) have you received from:

	Little or no support	Some support	A good level of support	Excellent support	N
Department of Health	19.5	70.7	7.3	2.4	41
NHS England	17.1	58.5	19.5	4.9	41
Public Health England	4.9	41.5	46.3	7.3	41
Local Government Association	9.5	28.6	45.2	16.7	42

DQ33/EQ19 In your work to improve public health, do you get the following support from Public Health England?

	DPH			Cab		
	No or not really	Yes to some extent	Yes fully	No or not really	Yes to some extent	Yes fully
Generating & sharing information	6.0	81.0	13.1	7.3	78.0	14.6
Synthesising knowledge and evidence of effective interventions	15.7	74.7	9.6	25.0	69.4	5.6
Professional and scientific expertise	15.5	63.1	21.4	36.1	47.2	16.7
Help to develop the public health system and its specialist workforce	35.4	59.8	4.9	42.9	40.0	17.1
Encouragement with discussions and supporting action	19.5	59.8	20.7	41.5	46.3	12.2

DQ34-35/EQ20-21 – comments

DQ36/EQ22 Are you a member of the Health and Wellbeing Board (in the upper tier/unitary level authority you are answering for)?

	HWB Member	Not a HWB Member
DPH survey	96.5	3.5
Elected member survey	97.9	2.1

DQ37/EQ23 In your opinion is your Health and Wellbeing Board:

		Definitely	To some extent	Not really	N
Strengthening relationships between commissioning organisations?	**DPH**	39.5	51.9	8.6	**81**
	Elected member	77.3	18.2	4.5	**44**
Facilitating the greater use of collective budgets?	**DPH**	**12.3**	**55.6**	**32.1**	**81**
	Elected member	**43.2**	**50.0**	**6.8**	**44**
Helping to foster a collective responsibility for the use of budgets?	**DPH**	**9.9**	**63.0**	**27.2**	**81**
	Elected member	**40.9**	**45.5**	**13.6**	**44**
Instrumental in identifying the main health and wellbeing priorities?	**DPH**	**60.5**	**33.3**	**6.2**	**81**
	Elected member	**86.0**	**14.0**	**0.0**	**43**
Successfully incorporating active citizen involvement?	**DPH**	**9.9**	**42.0**	**48.1**	**81**
	Elected member	**15.9**	**68.2**	**15.9**	**44**
Directly commissioning services?	**DPH**	**1.2**	**11.1**	**87.7**	**81**
	Elected member	**16.3**	**37.2**	**46.5**	**43**
Making difficult decisions?	**DPH**	**6.2**	**30.9**	**63.0**	**81**
	Elected member	**34.9**	**51.2**	**14.0**	**43**
Beginning to address the wider determinants of health?	**DPH**	**23.5**	**49.4**	**27.2**	**81**
	Elected member	**59.1**	**36.4**	**4.5**	**44**
Influencing cross-sector decisions and services to have positive impacts on health and wellbeing	**DPH**	**14.8**	**64.2**	**21.0**	**81**
	Elected member	**50.0**	**43.2**	**6.8**	44

DQ38/EQ24 How do you see your role on the Health & Wellbeing Board?

	DPH survey	Elected member survey
Being on the HWB has allowed me to influence decision-making in my own organisation	65.9%	82.6%
Being on the HWB has allowed me to influence decision-making in other organisations locally	67.5%	65.2%
Being on the HWB has allowed me to strategically influence work in the local health/social care economy	76.8%	65.2%
Being on the HWB has allowed me to engage with the development of the Better Care Fund	67.1%	82.6%

DQ39 How many CCGs are there in your local authority area?

		Frequency	Valid Percent
Valid	1	60	73.2
	2	8	9.8
	3	7	8.5
	4	2	2.4
	5	2	2.4
	6	2	2.4
	7	1	1.2
	Total	82	100.0

DQ40 In the last 12 months, have you/your team provided the following services or advice to the local CCG(s)?

Help with strategic planning / assessing needs	100.0%
Help with reviewing service provision	87.8%
Help with deciding priorities	85.4%
Help with monitoring and evaluation	73.2%
Help with procuring services	39.5%
Other	8.3%

DQ41 Is the capacity of the public health team sufficient to be able to:

	Yes - always	Yes - sometimes	Not really	Not at all
Ensure constructive relationships between the Local Authority and the CCG(s)	32.1%	43.2%	23.5%	1.2%
Allocate appropriately trained and accredited public health specialists to the provision of CCG support	28.4%	40.7%	28.4%	2.5%
Provide inputs that are sensitive to the needs of and individual priorities of each CCG	32.1%	45.7%	21.0%	1.2%
Provide clear actionable recommendations to assist clinical commissioners, based on public health analysis/skills	31.3%	47.5%	20.0%	1.3%
Provide a timely response to requests for input	31.3%	56.3%	15.0%	0.0%

DQ42 Since the April 2013 reforms, have you made any changes to services commissioned under the ring-fenced Public Health budget?

		Frequency	Valid Percent
Valid	Yes	78	94.0
	No	5	6.0
	Total	83	100.0

DQ43 Since April 2013, has your local authority…

Set up new services	68.8%
Changed provider	68.3%
Re-designed existing services	86.6%
De-commissioned services	57.5%

DQ44 Have the changes to commissioning arrangements since April 2013 led to any changes in obesity and weight management services in your local authority? (% of N=96)

No change in the level of commissioning of weight management	40.6%
Commissioning of new services to support weight management	34.4%
Decommissioning of previously existing services to support w	14.6%
Other changes to the provision of weight management services	15.6%

EQ25 Would you like to see your Local Authority change the way it goes about improving the health of your local population? (please tick one) (% of elected members)

		Frequency	Valid Percent
Valid	Yes, I would like to see us change (please specify in the the text box below)	20	45.5
	No, I think we have it about right	24	54.5
	Total	44	100.0

DQ45-46/EQ27-28 - comments

Appendix 2. DPH survey

Appendix 3. Elected member survey