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

FINDINGS FROM SURVEYS OF DIRECTORS OF PUBLIC HEALTH AND ELECTED MEMBERS IN ENGLISH LOCAL AUTHORITIES 2014 AND 2015 – SECOND SURVEY REPORT

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Disclaimer

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List of Abbreviations

ADPH	Association of Directors of Public Health
CCG	Clinical Commissioning Group
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
NHS	National Health Service
NHSE	National Health Service England
PHE	Public Health England

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Executive Summary

This report presents the findings from two national surveys conducted as part of the PHOENIX project. The PHOENIX project examined the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health, following the transfer of public health teams from the NHS into local authorities. The surveys were designed to complement other parts of the study, by describing the national situation, providing background and context for case studies, identifying change over time, and informing and testing the generalisability of findings from other parts of the study. The number and quality of survey responses were considered to provide robust and reliable findings.

Findings are presented from the 2015 surveys of Directors of Public Health (DsPH) and elected members leading on public health in local authorities. The report highlights similarities and differences between these two perspectives, and where there have been changes compared to 2014. Results are also examined for the subset of authorities where we had DPH replies in both years, to see if the experience in individual authorities differed from the overall pattern.

Our surveys have shown levels of change at two points in time following the transfer of public health responsibilities in April 2013. The changes varied in their speed and scale, for example the re-structuring provided the stimulus to re-think the contracts for health improvements: being located in local authorities made a broader approach to health possible, there was a greater readiness to abandon poorly performing contracts, and consequent changes resulted in fewer contracts and more integrated services, all of which might have made commissioning more efficient and cost-effective. The picture of change was similar in the commissioning of services in the area of obesity and weight management which was a particular focus of the PHOENIX project.

The research has illustrated that while both DsPH and elected members were very positive about the new opportunities for public health, there were also many challenges such as the turbulence of re-structuring, and the merging of differing cultures and values. All of these factors occurred against a backdrop of significant reductions in local authority funding. We found no clear geographical, administrative, social or economic patterning for where the transfer of public health teams to local authorities had worked particularly well, although some variations were detected. DsPH and elected members attributed a successful transfer to high quality leadership, demonstrable expertise of the public health team, good support from Chief Executive, and strong managerial processes and lines of communication. There was considerable agreement between DsPH and elected members on this, suggesting that the precise arrangement or organisation of public health was not indicative of successful integration and influence of public health across the authority and beyond.

Another clear message from our surveys was that change continues to happen. Changes that were expected in the first year were followed by more in year two, such as turnover in staff, new sharing arrangements between authorities, public health staff being moved around within the authority, DsPH moving on and off corporate management teams, DsPH continuing to gain more responsibilities and so on. Constant restructuring and organisational change were seen as increasingly challenging, and some DsPH were doubtful that they had the capacity to continue meeting the information needs of Clinical Commissioning Groups.

The views of DsPH and elected members were similar in a number of areas, such as thinking the transfer had been successful, that the public health team had settled in well and had become valued and trusted. Both DsPH and elected members also acknowledged that there were cultural differences, with public health's rational and evidence-based approach compared to the need for councillors to consider the demands of politics and the local electorate. In some areas, DsPH were more critical or more pessimistic than elected members - for example, DsPH gave a low rating to the support they received from PHE, NHSE and other external agencies, lower ratings for the performance of the HWB, DsPH felt less influential and saw more barriers to successful integration compared to elected members. Differences in perspective were partly due to the fact that elected members were initially very positive in all these areas, and to some extent have moderated their views over time so the views of DsPH and elected members have become more similar.

Compared to other research, the results reported here are based on a more comprehensive approach to getting the views of elected members leading on public health by writing to all in upper tier authorities in England. It has also been possible to compare the views of public health professionals to those of councillors, and examine changes in individual authorities over time.

Introduction

This report presents findings from national surveys conducted as part of the PHOENIX project. The PHOENIX project examined the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health. The overall study incorporated multiple methods, including key informant interviews, document analysis, local case studies and the national surveys, and results have been published in a scoping review, an interim report, a previous survey report and a final report (Gadsby et al 2014; Peckham et al 2015, Jenkins et al 2015a, Peckham et al 2016).

The surveys reported here were designed to complement other parts of the study, by describing the national situation from two perspectives (directors of public health and elected members), providing background and context for the case study sites, identifying change over time, informing the case study research, and testing the generalisability of findings from other parts of the study. All Directors of Public Health (DsPH) and elected members (councillors) with a responsibility for public health in the 152 English unitary and upper-tier authorities were surveyed in 2014 and again in 2015. The focus of the questions 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. We also examined the relationships of public health teams within their local authority and beyond.

The first year's survey results have been published in research reports (Peckham et al 2015, Jenkins et al 2015a) and a journal article (Jenkins et al 2015b). This report presents the results of the second survey carried out in September/October 2015 and looks at year on year changes in the organisation and functioning of public health following its move to local authorities in April 2013.

Background

Our surveys were designed to meet the aims of the PHOENIX project but were also influenced by previous research on the implications of the reforms for public health staff, structures and practices. Prior to 2014, other researchers had carried out surveys in the same area, and the types of questioning and response rates of these informed the development of our survey design. These studies 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 also included: that councils had welcomed public health teams; relationships were still developing; that public health officers had good access to councillors; public health officers had an increased ability to have an influence more widely within the authority and beyond; and (prior to our surveys) that changes in commissioning for health improvement were slow to start. The studies raised several concerns: that HWBs lacked statutory powers that could affect their impact; public health teams would find big cultural differences and need to change the way they operated; 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 they did not appear to have been surveyed, but could be seen in a small number of case studies (Local Government Association 2014a, Local Government Association 2014b).

Our 2014 national surveys within the PHOENIX project, which have been previously published, also confirmed the variety of organisational arrangements and managerial accountability for DsPH and their teams. We showed the different perspectives of DsPH and councillors on public health's influence and budgetary responsibility, and found high levels of change in commissioning from the public health budget. Our 2014 surveys found respondents positive in regard to building relationships within local authorities and beyond, and more negative concerning reductions in public health staff and support from Public Health England (PHE).

Method

The 2015 survey conduct and design was broadly a repeat of that in 2014 (see details in survey report Jenkins 2015a). All DsPH and elected members with the public health portfolio in upper tier and unitary authorities in England were sent a personally addressed email and invited to take part in our online survey. As in 2014, the survey for DsPH was longer and more detailed than that for elected members. The survey questions asked how public health teams were organised and managed, whether there were sharing arrangements between local authorities and whether there had been changes in responsibilities and funding for public health. It also asked how well the public health team was functioning and having influence across the local authority, relationships with PHE, Health & Wellbeing Boards (HWBs), Clinical Commissioning Groups (CCGs) and other external organisations, and about changes in commissioning for health improvement funded from the public health budget. In the 2015 survey we added some additional questions asking if further re-structuring of public health departments was occurring and for responses to the 6.2% cut to public health budgets announced in 2015 (Department of Health 2015). Some questions used in the 2014 surveys were dropped as it seemed they were unlikely to provide new information, so the surveys were a little shorter in 2015 (see the questionnaires in Appendices 1 and 2). The surveys were sent to the Association of Directors of Public Health (ADPH Chief Executive Nicola Close) and other experts (Paul Ogden, David Hunter, Harry Rutter and Simon Reeve) for comment prior to circulating to DsPH and councillors.

An up to date mailing list of DsPH was provided by ADPH, who also promoted our survey through their weekly email to DsPH. The names of councillors leading on public health and their email addresses were obtained from council websites in August 2015. Invitations to take part were mailed out in September followed by two reminders if there had been no response after 10-14 days. As the response from DsPH was lower than the previous year, a third reminder was sent to them.

Responses were downloaded into a statistics package (SPSS), the data was cleaned and checked, then analysed using descriptive tabulations and statistical tests of association and difference.

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

Results

Findings are presented from the 2015 surveys of DsPH and elected members leading on public health, highlighting similarities and differences between their two perspectives, and where there have been changes compared to 2014. Summaries and analyses of the free text comments are given where these add to and clarify the findings.

Results are also examined for the subset of authorities where we had DPH replies in both years, to see if the experience in individual authorities differed from the overall pattern. Some further analyses are included that searched for evidence of intended and unintended consequences of the April 2013 reforms or that suggests that their impact was uneven. These further analyses took the form of cross-tabulations and statistical tests for associations between key survey variables such as those describing public health roles, responsibilities and influence, and how commissioning for health improvement has changed. It should be noted that the number of replies affects the size of change in the data that can be regarded as ***statistically significant with a 95% confidence level, and when comparing proportions in these surveys, differences of at least ten percentage points for DsPH overall, twelve percentage points for the year on year comparison of DsPH replies, and at least 15 percentage points for elected members are needed***.

A full set of responses to all the questions in 2015 and 2014 surveys can be found in Appendix 3, with DPH question numbers prefixed 'DQ' and elected member question numbers prefixed 'EQ'. Appendix 4 shows change over time in the subset of local authorities that replied to the DPH survey in both years.

Response and representativeness of the response

There were 74 replies in the DPH survey (49% response rate) after combining duplicate replies from one local authority (LA), and there were 48 replies in the survey of elected members with the public health portfolio (32% response rate). Feedback from two people who did not complete the survey reflects the pressure they were under. A councillor wrote: 'I will try and do this for you but… …I have been chair for such a short time. I am frantically busy at present but I will try… …and have another go soon. I am very sorry.' And a DPH emailed: ' I really would like to fill this survey in, but working on in-year and potentially recurrent public health budget cuts across two local authorities in addition to the day job, means that I literally don't have time (even at the week-end). Perhaps this says something in itself....'

Most of the replies were complete, and in 2015 all contained some useful information so have been included in the analysis, which accounts for changes in the number of replies to individual questions presented in this report. Of the 152 upper tier and unitary authorities in England, 96 (63%) are represented in the replies. Replies from both the DPH and elected member were only received in 26 (17%) of the authorities. In the DPH survey there were 59 LAs that replied in both 2014 and 2015 surveys, and in the elected member survey there were 23 LAs that replied in both years. This represented a large proportion of DsPH (80%) compared to elected members (48%) in 2015 who had also replied in 2014.

The overall response was better in the DPH surveys (39% of LAs replied in both years and 34% of LAs replied in one year), making the DPH results and year on year comparisons for DsPH more reliable

than the elected member survey, where response rates were lower and a smaller proportion of authorities replied in both years.

The distribution of survey responses was compared to all England authorities in terms of the spread across regions, different types of authority, the political party in power, population size, levels of material deprivation and the per capita public head budget (see Appendix 5). In the 2015 surveys, apart from some under- and over-representations of elected members by region, the overall pattern was similar, and in particular the subset of 59 authorities where we had a DPH reply in both years was highly representative of the 152 English authorities being sampled.

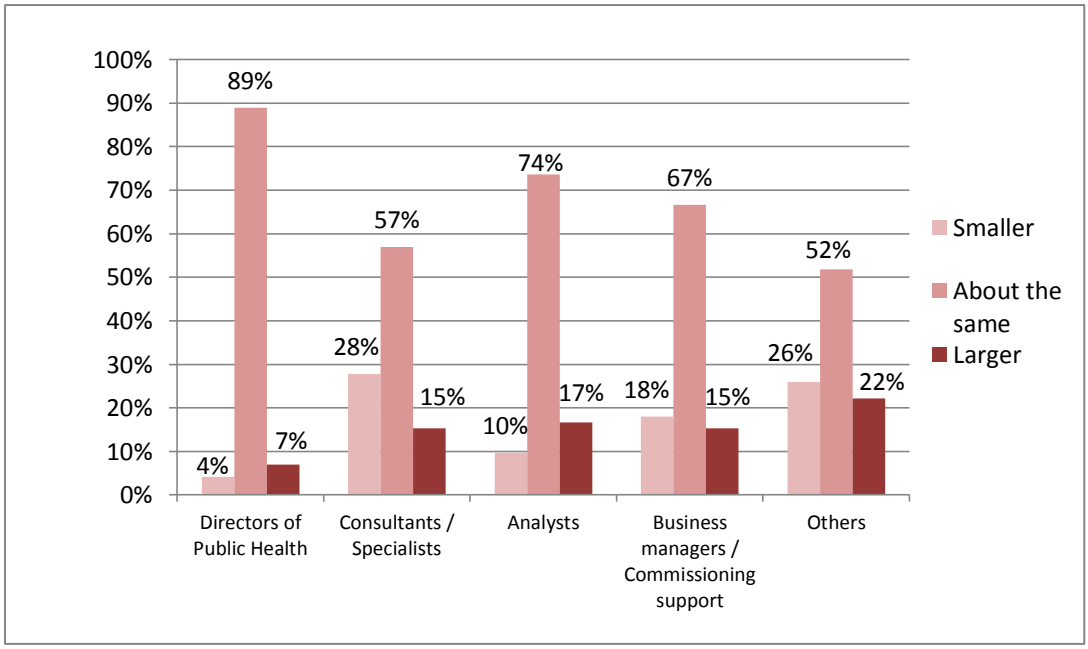
Organisational arrangements of public health in local councils [DQ1-14, EQ1-3]

Nearly a third of the authorities (32% N=74) replying said their public health team delivered a service that was shared, and for 5 authorities this was a new, if only temporary, arrangement. Sharing arrangements were usually between unitary authorities. (See tabular results for DQ1-4 in Appendix 3.)

Three quarters of the respondents were DsPH with at least a year's experience in the authority. The 2015 survey showed no change in the proportion of acting or interim DsPH (7% N=74) and an increased proportion of DsPH with several years' experience in their authority and in their post. However, the year on year data exposed a somewhat different reality in that only 79% of authorities (N=57) had the stability of having a substantive DPH in post both years, and for the remainder there were other arrangements or changes in leadership, including switching between established and acting DsPH, and some newly appointed DsPH. This meant that there was a mix of stability and turnover among those in the role of DPH. Replies from the survey of elected members showed that all were members of the council's cabinet or executive team, but quite a few of these were new to the authority or their role (30% N=47 in 2015, compared to 10% N=51 in 2014 had held the health portfolio for less than a year). (See tabular results for DQ5-7/EQ1-3 in Appendix 3 and DQ6-7 in App 4.)

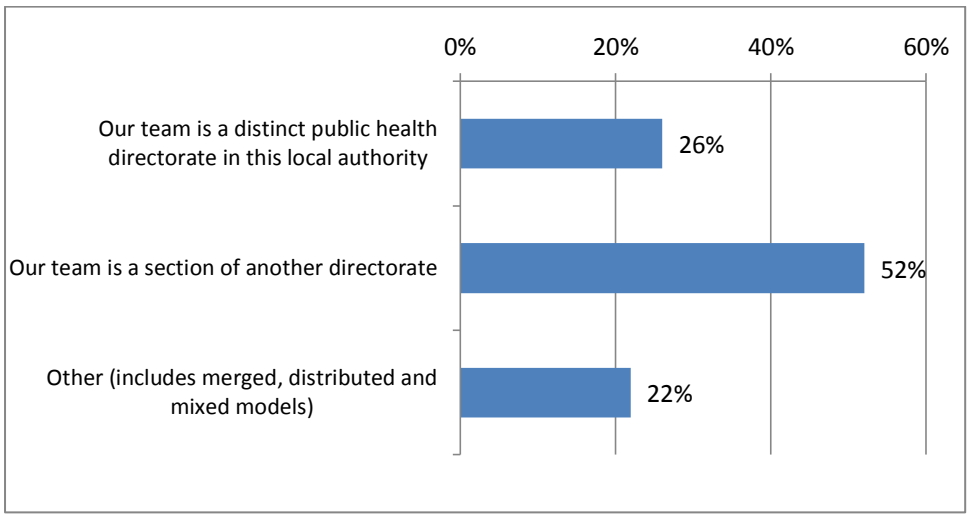
DsPH were asked if there had been changes in the size and composition of the public health team since transferring from the NHS, and the replies suggested that the situation had not altered since the 2014 survey, with significant losses in the numbers of consultants and specialists. (See fig 1 and DQ8 in App 3.)

Figure 1. Changes in the last 12 months to size and composition of the public health team (2015 DPH survey N=72)



When asked how the public health team was arranged, the overall profile was very similar to the previous survey. In 2015, just over a half were part of another directorate (38 out of 73, 52%) and just over a quarter were a distinct public health directorate (26% N=73). The year on year comparison showed this masked a much higher level of organisational changes, as 43% of public health teams (24 out of 56) were in a new arrangement - for example, five of these had set up a distinct public health directorate since 2014 and seven no longer had a distinct public health directorate. (See fig 2 and DQ9 in App 3 and 4.)

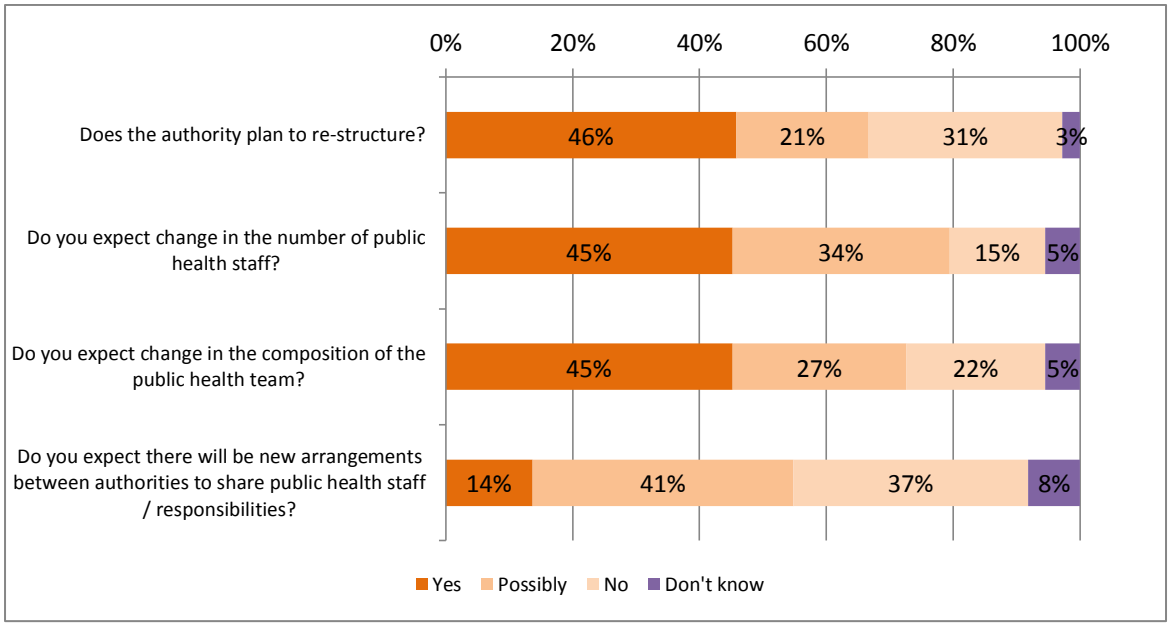
Figure 2. How is your public health team arranged in this local authority? (2015 DPH survey N=73)



New questions were asked about plans for further changes affecting the public health team, which revealed that nearly a half said their authority planned to re-structure (46% N=72) and that they expected changes to the size and composition of the public health team (both 45% N=73). Quite

substantial proportions thought that re-structuring, or changes in size and composition of the public health team were 'possibly' going to happen (between 21-34% N=73). The survey also asked if respondents thought that there would be new arrangements between authorities to share public health staff or responsibilities, and although they thought that much less likely, 14% (N=73) expected such changes would happen. (See fig 3 and DQ10.1-10.4 in App 3.)

Figure 3. Are there plans affecting public health teams in the next 12 months? (2015 DPH survey N=73)



When the questions on re-structuring were cross-tabulated with other key variables (such as those describing public health roles, responsibilities and influence, and how commissioning for health improvement has changed), no statistically significant associations were found, suggesting that DsPH' views were not affected by the local arrangements or circumstances of their authority. However, there were indications that re-structuring was more likely in London Boroughs (83% N=12 said 'yes', compared to 46% N=72 for all LAs), and similar to replies to the first question about new sharing arrangements, there was less organisational change in two-tier authorities compared to unitary authorities (two-tier authorities were less likely to think that new sharing arrangements for public health responsibilities or staff would be introduced in the next 12 months with none N=16 saying 'no', compared to 37% N=73 for all LAs). Differences between authorities were quite sizeable but, as already mentioned, not statistically significant.

Nearly a half of those in the DPH survey were managed by the Chief Executive, slightly more than in 2014 (42% N=91, now 47% N=73). (See DQ11 in App 3.)

In 2015 the overall proportion of DsPH who were members of the authority's most senior corporate management team had not changed (53% N=73), and all had access to elected members. The year on year comparisons for authorities that replied in both years again showed that overall proportions could remain steady yet mask a considerable amount of change in individual authorities. For example, between 2014 and 2015, 7% (N=56) of DsPH had moved onto and 20% (N=56) of DsPH

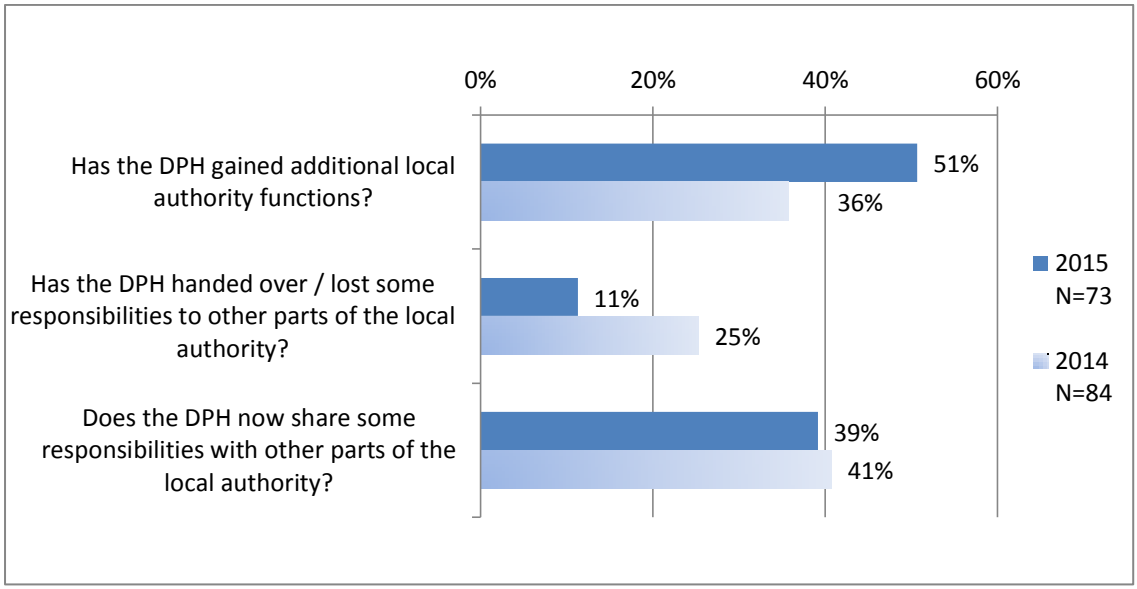
were no longer on the most senior corporate management team. (See table 1 and DQ12-13 in App 3 and 4.)

Table 1. Are you a standing member of your local authority's most senior corporate management team? (sub-set of LAs replying in both 2014 and 2015 DPH surveys N=56)

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

When asked about changes in responsibilities, more DsPH in 2015 said they had gained additional responsibilities (51% N=73 in 2015 compared to 36% N=84 in 2014) and fewer had handed over responsibilities to other parts of the authority (11% N=71 in 2015 compared to 25% N=79 in 2014). The free text replies gave more details, showing that DsPH were taking on responsibility for areas like leisure, culture, libraries, environmental health, as well as adult social care and early years. (See fig 4 and DQ14 in App 3 and 4.)

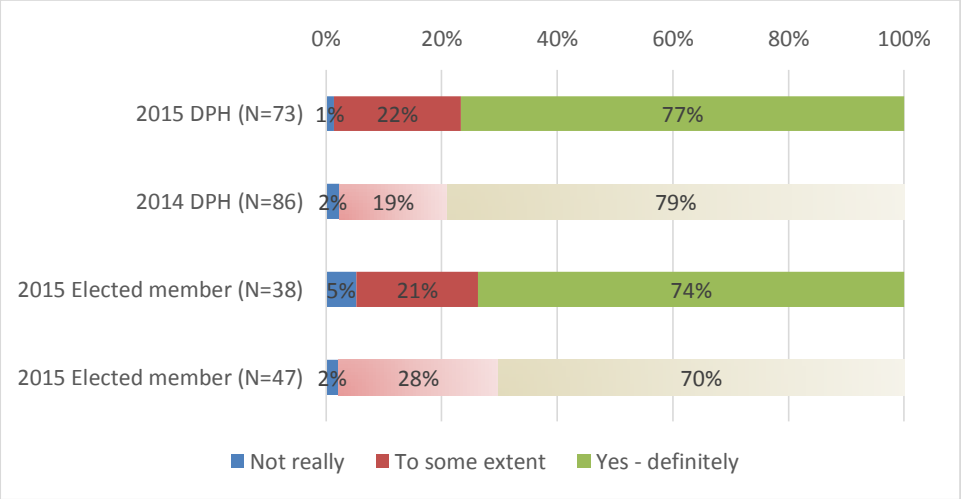
Figure 4. Have there been changes in the last 12 months in DPH responsibilities? (DPH surveys)



Integrating and developing relationships [DQ15-25, EQ4-13]

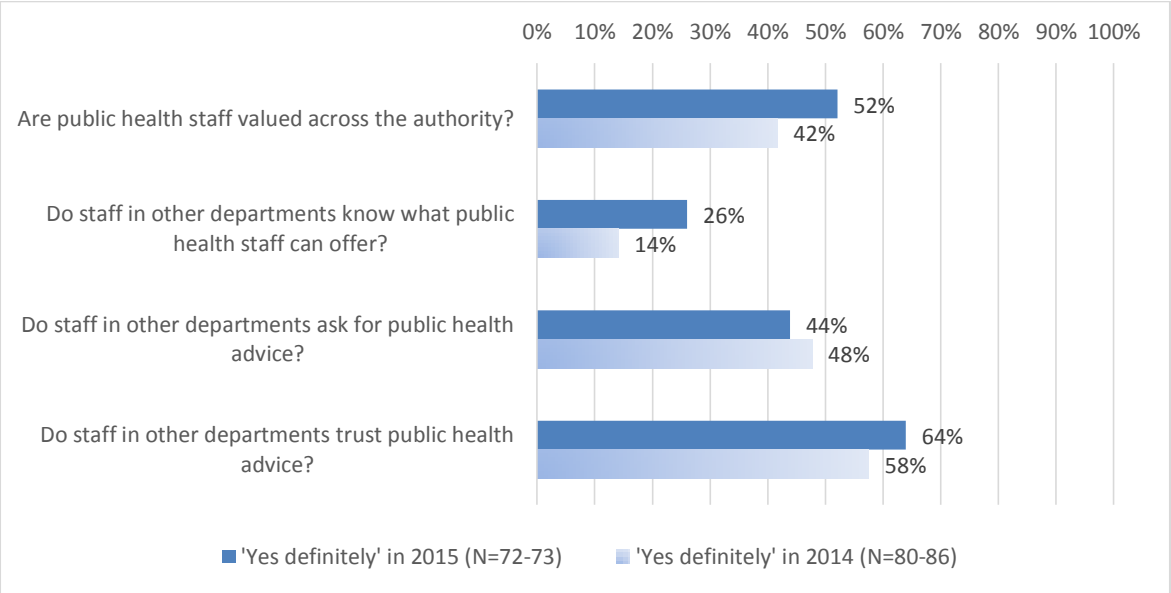
The surveys continued to demonstrate the view of both DsPH and elected members that public health staff have 'definitely' built good relationships within the authority (77% and 74% respectively said this in 2015, see fig 5 and DQ15.1/EQ4.1 in App 3 and 4).

Figure 5. Have public health staff built good relationships within the authority?



Similar to the previous year, the views were more equivocal that public health staff were 'definitely' valued (52% of DsPH and 61% of elected members said this, see fig 6, and DQ15.2-DQ15.5/EQ4.2-EQ4.5 in App 3), and that staff in other departments asked for advice (44% DsPH said this) and trusted public health advice (64% DsPH said this). Although there had been an increase in the proportion of DsPH who thought that staff in other departments knew what public health staff could offer, this still remained at only 26% (N=73) saying 'definitely' (up from 14% N=85 in 2014). The authorities supplying DPH responses in both years showed that progress had been made in knowing and trusting in what the team could offer, and in particular confirmed the DPH view that there had been an increase in awareness of what the public health team could offer (see DQ15.2-DQ15.5 App 4).

Figure 6. How is the public health team embedded in the local authority? (DPH surveys)



Note: the figure shows responses to several questions, and a range in N gives the maximum and minimum number answering each of the questions (App 3 gives these details)

When cross-tabulating DsPH' answers on integration of the public health team, many statistically significant associations were found with other variables. Building a good relationship was seen as the best measure of integration available from the survey data, and it was found to be associated with the team being valued, being asked for advice, and their advice being trusted. It was also associated with active use of the public health team services such as provision of data, needs assessment and inequalities analyses. There was no association between having built a good relationship and the various measures of having influence within and beyond the LA. The only significant association to be found among the views of elected members regarding integration was between having built a good relationship and public health staff being valued.

DsPH and elected members were asked to give three enablers and three barriers to successful integration of public health within their authority. From the many free text responses a number of common themes have been identified, as described in the following paragraphs and summarised in table 2 below:

***Enablers seen by DsPH*:** The most cited enabler was good working relationships and team working across the organisation. Respondents reported that they had and continued to build relationships which allowed them to collaborate to deliver high quality pieces of work. Another key enabler was experiencing strong support from the Chief Executive, Cabinet Members, the DPH and the wider public health team. Respondents also cited that the bringing together and merging of work steams and priorities was a big enabler. Interestingly, a strong enabler was that respondents felt that the public health offering was better understood and that staff have begun to successfully raise their profile across the LA. Other enablers included: the availability of the ring-fenced grant, having a closely located team and a good team structure, and being able to use LA levers, skills and existing links.

Enablers seen by elected members: Cabinet members cited the biggest enabler to be the high quality, knowledgeable public health staff, with particular mention of the competence of the DPH. Further to that they noted the good working relationships amongst staff and across departments as being a key enabler. Another key element was the focus on integrated health and social care. Respondents also said that leadership was a significant component, particularly by the DPH and wider political leadership. Other enablers cited were good team organisation, in relation to the public health team being embedded in the council, having existing funding available, and the perception that public health has become more visible.

Barriers seen by DsPH: the biggest barrier was related to finance - specifically, financial pressure felt by the LA in the cuts, and the perception that there was too much focus on the ring-fenced grant and LA staff trying to use the ring-fenced grant to compensate for cuts in other service areas. Another main barrier was problems with staff. These problems included behaviour-related issues (such as being territorial and overly protective of roles and responsibilities), and lack of staff capacity and role clarity (which had caused issues in the context of integration and relationship building). Respondents cited that differences in ways of working were also an issue. For example, there were discrepancies between short and long term planning, governance processes, including decision making, and terms and conditions. Also mentioned were differences in working culture, with LAs leaning towards a more siloed working arrangement, and each speaking in different

"languages". Despite being cited as a big enabler, respondents said they still felt there was a lack of understanding about what public health does and a lack of prioritisation of the public health role.

Barriers seen by elected members: Cabinet members cited differences in ways of working and work priorities, including, confusion over roles and responsibilities and the silo working culture of LAs, and financial issues, such as budget cuts and over-reliance on the public health grant as the joint biggest barriers. Another major barrier was the perceived lack of understanding of the public health function amongst respondents. Differences in workplace culture and anxieties about the LA and public health merger were also cited as barriers.

Table 2. Summary of enablers and barriers to successful integration of public health

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

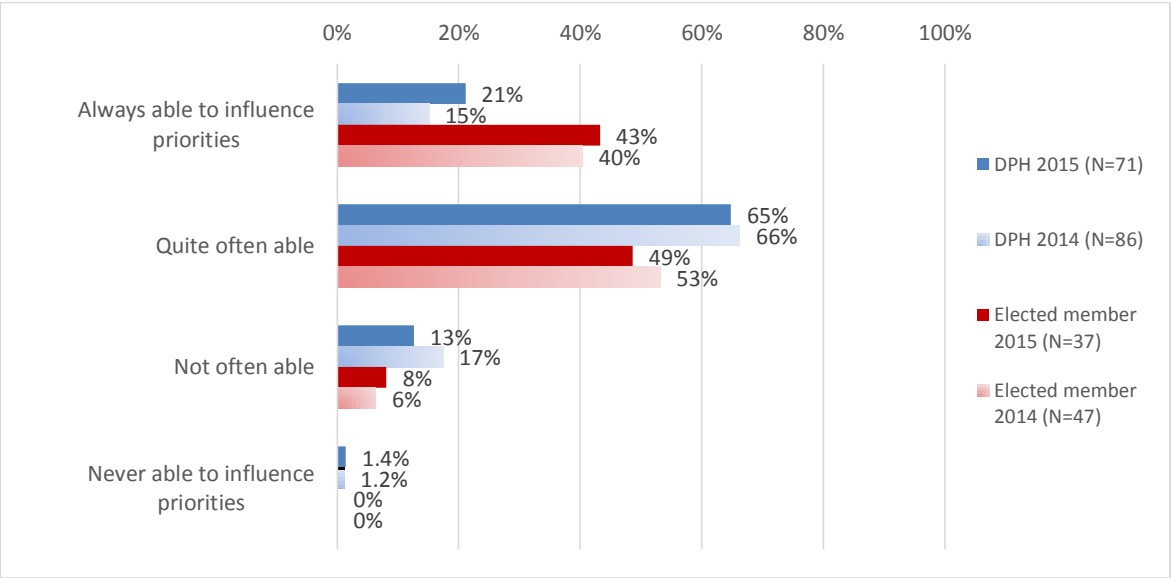
The 2014 survey asked DsPH and elected members about membership of various cross-departmental groups or committees, which showed that it was quite often the case that members of the public health team had a seat on the relevant committees, especially those for young people (92%, N=86) and older people (79%, N=86). (See table 3, and DQ[20] in App 3.)

Table 3. Do you sit on cross-departmental groups or committees focusing on the following areas? (2014 only)

	2014 DPH survey (N=86)	2014 Elected member survey (N=47)
Inequalities / social inclusion	65%	55%
Youth / young people	92%	38%
Older people	79%	75%
Regeneration / economic development	50%	26%
Environment / sustainability	65%	19%
Corporate strategy	65%	60%
Other	17%	19%

An important aspect of this research was to examine the impact of public health in its new setting, and the survey asked about the influence DsPH and elected members felt they had with respect to improving the local population's health. Most DsPH (65% N=71) said they were 'quite often' able, and there was a modest shift towards more DsPH saying they 'always' felt able to influence the priorities of their authority (21% N=71 in 2015, compared to 15% N=86 in 2014) and away from saying this was 'not often' the case (13% N=71 in 2015 compared to 17% N=86 in 2014). However in two-tier authorities in 2015, no DPH (0% N=15) felt they were 'always' able to influence their authority's priorities in regard to improving health. (See fig 7 and DQ18 and EQ7 in App 3.)

Figure 7. To what extent do you feel able to influence the priorities of your local authority?

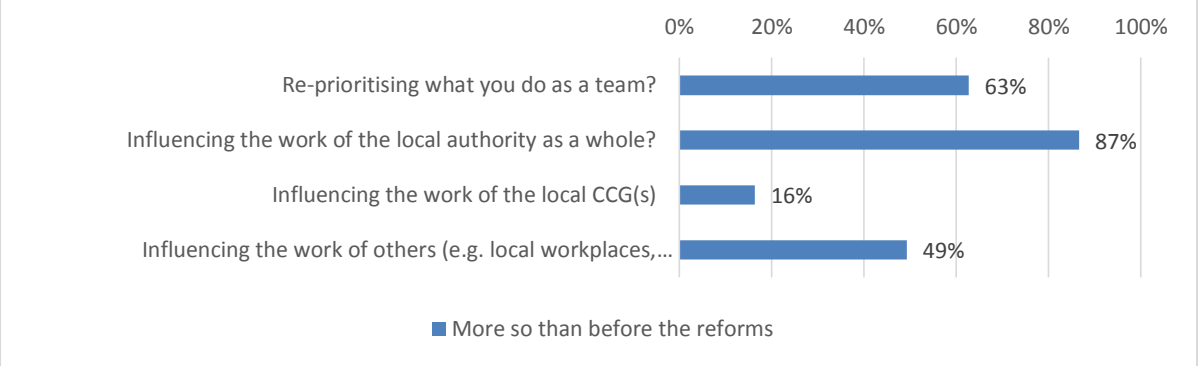


Elected members were asked the extent of their influence over the priorities of their local authority and in a second question, their influence over the priorities of the public health team. Results for elected members had hardly changed over time and in 2015, 45% (N=38) felt 'always' able, nearly half said 'quite often' able, and 8% 'not often' able to influence priorities of the authority and the public health team respectively.

Similar to what had been seen in 2014, there were some statistically significant associations between DsPH' perceived ability to influence priorities in their LA and other key variables. In 2015, the strongest associations were found between feeling influential and the DPH having gained additional responsibilities (a new finding), the public health staff being valued, others knowing what the public health team offered, the team being asked for advice and it being trusted (all chi-squares between 7.682 and 12.702, df = 2, p values between 0.002 and 0.021). When a DPH was a member of the most senior corporate management team this was associated with being 'quite often' able to influence LA priorities (chi-square = 6.282, df = 2, p=0.043). There was some association between the DPH's perception of their influence and the achievements of the HWB, for example the DPH saying that the HWB was 'definitely' beginning to address the wider determinants of health (chi-square = 17.878, df = 4, p = 0.001). No clear differences were seen for different types of local authority, although there was some indication that DsPH in inner London and south east authorities felt they had less influence, and those in non-London unitary authorities and the north west region had most. There was little of significance in the replies of elected members, only an association between how often they felt they had influence across the whole authority and how often they felt able to influence the priorities of the public health team (chi-square = 19.699, df = 4, p = 0.001). (See DQ18 and EQ7-8 in App 3.)

Both were asked the extent to which they felt they could deliver real improvements in local health. DsPH were more positive about the opportunity to re-prioritise what the public health team did (63% N=67 said 'always' in 2015, compared to 54% N=85 in 2014), although the subset of authorities for which we could make comparisons showed that for many, these ratings were changing from one year to the next. DsPH continued to agree that the reforms had made them 'more' able to influence the work of their local authority (87% N=67 in 2015, compared to 82% N=85 in 2014). Respondents remained divided (49% N=69) on whether they were 'more' or 'similarly' able to influence elsewhere (schools, workplaces, etc), and felt 'less' able to influence the work of CCGs (48% N=67 in 2015, compared to 37% N=85 in 2014). The comments illustrated different experiences in different LAs - for example, some were positive about the possibilities of looking more holistically at public health and working with CCGs and workplaces, while others said progress was slow and uneven between LAs, and the setting up of academies had led to a loss of influence in schools. (See fig 8 and DQ19 and EQ9 in App 3 and 4.)

Figure 8. To what extent do you feel able to deliver real improvements in local health by: (2015 DPH survey N=67-69)

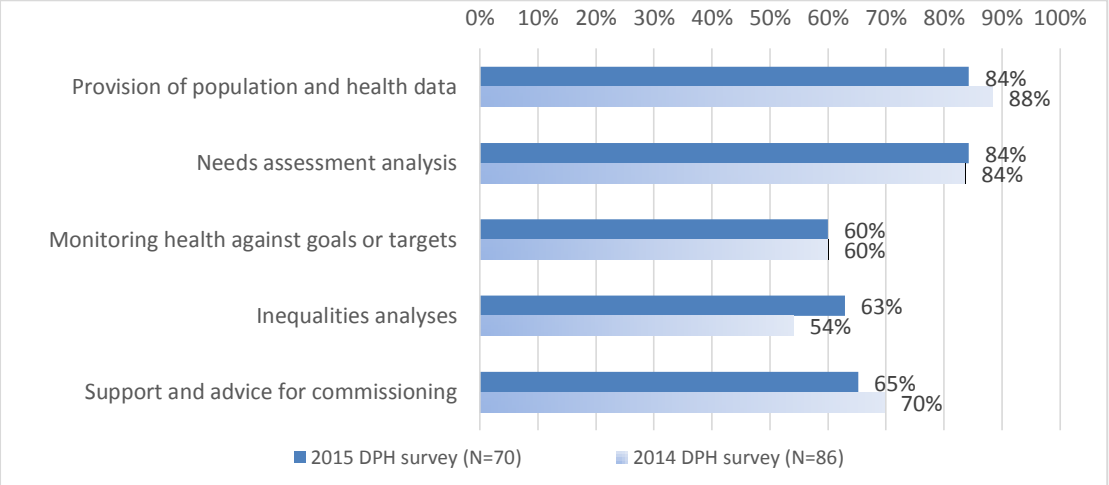


Note: the figure shows responses to several questions, and a range in N gives the maximum and minimum number answering each of the questions (App 3 gives these details)

Since 2014 there had been an increase in authorities with a requirement for other departments always to collaborate with public health on their plans (34% N=67 in 2015, compared to 15% N=85 in 2014), a shift that was echoed in the subset for which we could make year on year comparisons. The comments showed that collaboration was additionally happening or being worked towards in other authorities without a requirement to do so. (See DQ20 in App 3.)

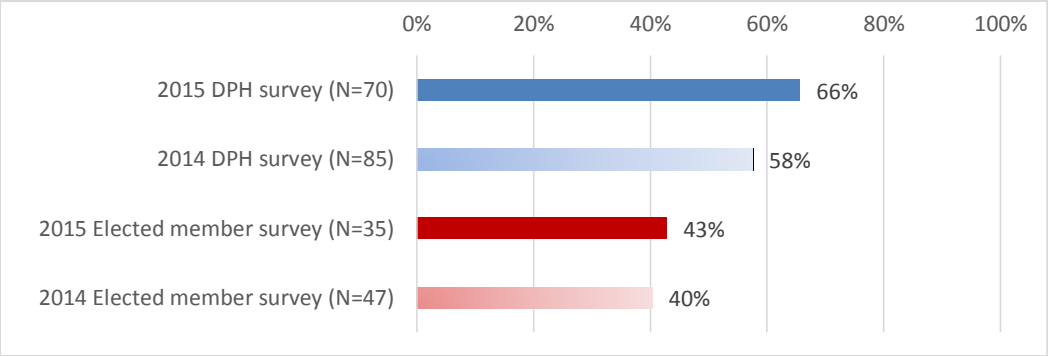
Regarding the support that the public health team offered and how actively it was used, results were broadly the same as the 2014 survey. For example, in 2015 more DsPH than elected members said that population and health data and needs assessment analysis were 'actively' used (84% N=70 for both types of support, compared to elected members saying 70% and 65% N=37), and there was closer agreement between the two perspectives on monitoring data, inequalities analyses and support for commissioning with 60-70% (N=70 for DsPH and N=37 for elected members) saying each of these types of support were 'actively' used (Fig 9 shows the DPH responses). The comments showed that public health teams were also providing leadership and advice on policy and strategy development. (See DQ21 and EQ10 in App 3.)

Figure 9. What support do you/ the public health team offer to others/ elected members in your local authority? % saying 'Yes, and actively used' (DPH surveys)



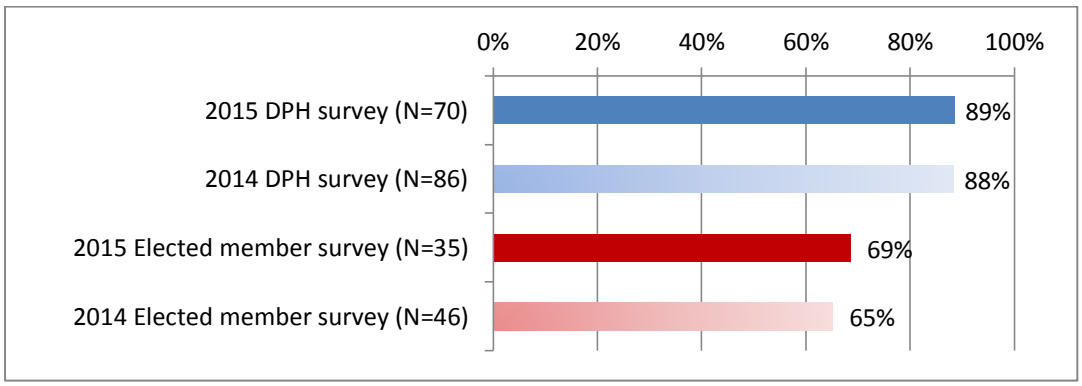
When asked who authorised expenditure from the public health budget, there was a small increase in the proportion of DsPH saying it was them alone (66% N=70 in 2015, compared to 58% N=85 in 2014 Fig 10), with only very few saying it was in the hands of others (4% in 2015, compared to 14% in 2014). The survey of elected members did not reflect any change over time, with 43% N=35 in 2015 saying that DsPH alone authorised expenditure, and 43% that DsPH shared the responsibility. The subset of local authorities where we could see year on year change showed that, underneath an apparently static situation, there had been changes in who authorised expenditure of the public health budget in nearly a third of the authorities (31% N=51). (See DQ22 and EQ11 in App 3 and 4.)

Figure 10. Who authorises expenditure from the ring-fenced public health budget? – Director of Public Health alone



Further questions were asked about the public health budget, with some DsPH (26% in 2015, compared to 19% in the previous year) saying that additional funds had been made available for the public health team's work, for example from CCGs or the council's commissioning budget. Referring to the last 12 months, 89% of DsPH (N=70) and 69% of elected members (N=35) in the 2015 surveys said that the ring-fenced public health budget had been used to invest in other local authority departments, a level of response that was similar to that in 2014 (Fig 11). The comments indicated that such investment was across an extremely wide range of the council's activities, including sport and leisure, children's services, housing, employment, resilience, road safety, and so on, and that some investments would prevent services being cut. The extent to which DsPH and elected members leading on health felt the DPH had influence over other departments' expenditure also remained constant (13% of DsPH and 21% of elected members said 'yes, quite a lot' in 2015, whereas 39% of DsPH and 30% of elected members said the DPH had no influence). The year on year comparisons of public health's influence over other departments' expenditure showed that underneath the overall lack of change, there had actually been quite a lot of movement and only half of the DsPH (52%) gave the same answer to this question in both years. The comments showed that some influence was exercised through having budgetary responsibility, and some through participating in policy and strategy development. (See DQ23-25 and EQ12-13 in App 3 and 4.)

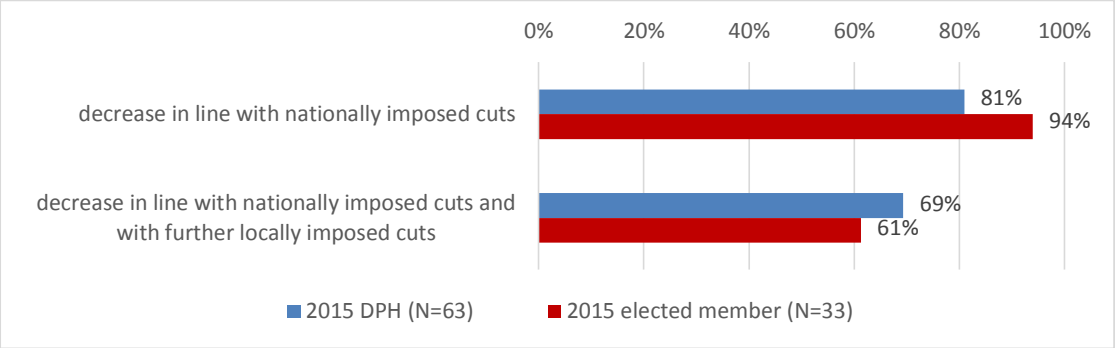
Figure 11. In the last 12 months, has the ring-fenced public health budget been used to invest in other local authority departments?



Protecting public health spending and making cuts [DQ26-28, EQ14-16]

New questions in 2015 asked about the local authorities' plans in the light of the removal of the ring-fence around the public health budget and forthcoming cuts to public health funding, although it was subsequently announced in the Chancellor's 2015 autumn statement that the ring fence would be maintained in 2016/17 and 2017/18 (HM Treasury 2015). In our survey, 94% of DsPH and 91% of elected members said their authority had not made a commitment to protect the level of public health spending when the ring-fencing was removed. The six authorities (four from the DPH survey and two from the elected member survey) who had made a commitment were all unitary authorities (none in London) with populations of less than 450,000, and all four DsPH were on the senior corporate management team. Most DsPH (81%) and elected members (94%) expected expenditure to decrease in line with the 6% nationally imposed cuts, and around two thirds (69% and 61% respectively) expected further locally imposed cuts to expenditure (Fig 12). DsPH comments suggested that the public health budget was expected to contribute to the overall savings that councils needed to make, whereas some elected members felt it was too early to be certain of that. (See DQ26-27 and EQ14-15 in App 3.)

Figure 12. Do you expect expenditure to decrease in line with nationally imposed cuts? (2015 only)



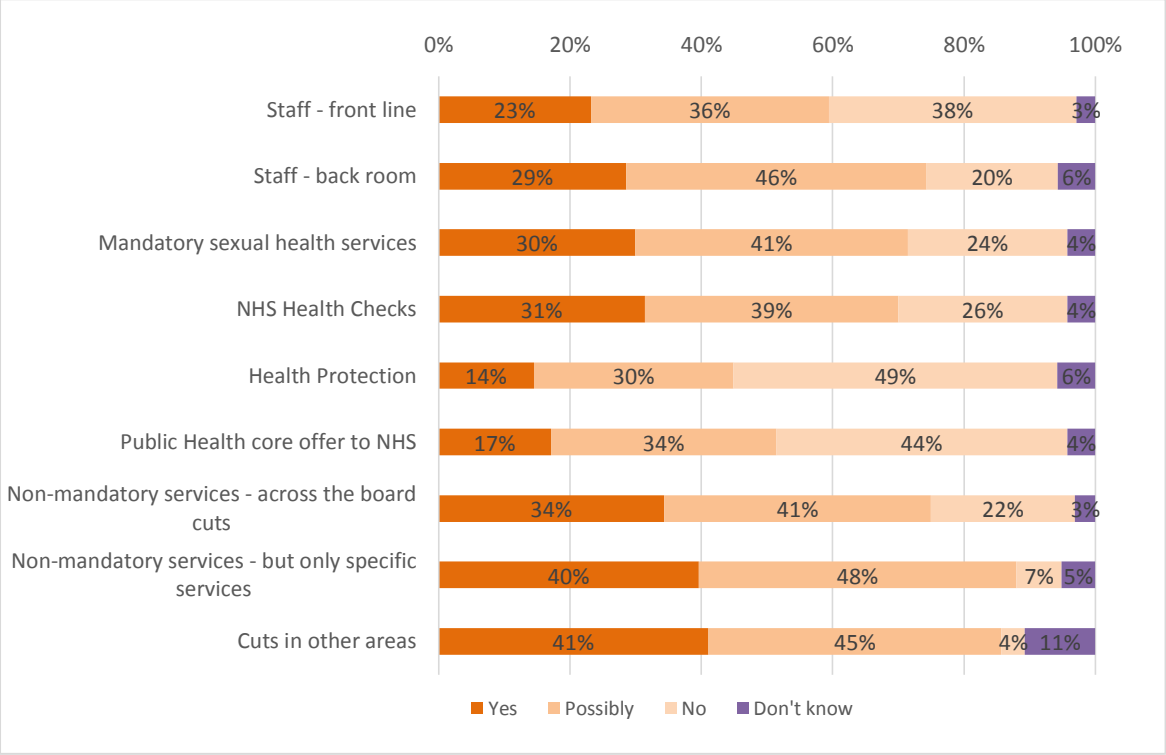
The survey asked if each of the following areas had been identified as areas to be affected by cuts in the public health budget:

- Staff – front line
- Staff – back room
- Mandatory sexual health services
- NHS Health Checks
- Health Protection
- Public health core offer to the NHS
- Non-mandatory services – across the board
- Non-mandatory services – but only specific services
- Cuts in other areas

There were some differences between DsPH' and elected members' views on where the cuts might fall (Fig 13). For DsPH, over a third expected 'cuts in other areas' (41%) and cuts in non-mandatory services (40% said 'yes' for specific non-mandatory services and 34% said 'yes' for non-mandatory services across the board), followed by NHS Health Checks, mandatory sexual health services and backroom staff (where 29-31% said yes), and cuts to the public health core offer to the NHS and health protection were least likely (44-49% of DsPH said they did not expect cuts). However, many

DsPH said cuts in all these areas were possible (30-48% said 'possibly'). Half the DsPH added comments on areas to be cut, saying things like 'many areas', 'everything is up for cuts', or listing many areas; some were expecting cuts to be more targeted, such as cuts to drug and alcohol teams (DAAT) and sexual health services; and a few talked of 're-phrasing' and 're-positioning' their investment, or looking for better value for money. Fewer elected members than DsPH were expecting cuts, with only 10-12% saying it would be the case for back room staff, mandatory sexual health services, NHS Health Checks and non-mandatory services, and lower percentages expecting cuts elsewhere. Elected members agreed with DsPH that cuts were possible across the whole range of areas the survey asked about (37-64% said 'possibly'), but they were less convinced than DsPH that back room staff, the public health core offer to the NHS and health protection were safe from cuts. Elected members' comments on the specific areas likely to be affected echoed those of DsPH. (See DQ28 and EQ16 in App 3.)

Figure 13. Have you identified areas to be affected by cuts in the public health budget? (2015 DPH survey N= 64-70)



Note: the figure shows responses to several questions, and a range in N gives the maximum and minimum number answering each of the questions (App 3 gives these details)

Cross-tabulations and tests of association showed some quite large (but not statistically significant) variation in views about changes in public health expenditure. For example, expectations of national plus further local cuts were higher in London boroughs, where cuts to front line and back-room staff and the core public health offer were seen as more likely to happen. DsPH in two-tier authorities were least likely to be expecting cuts to affect mandatory services such as NHS Health Checks and health protection. These findings are mentioned as, when seen together they suggested a pattern, even though they were not statistically significant individually. There was one statistically significant association regarding future cuts in public health expenditure, namely that DsPH managed by the

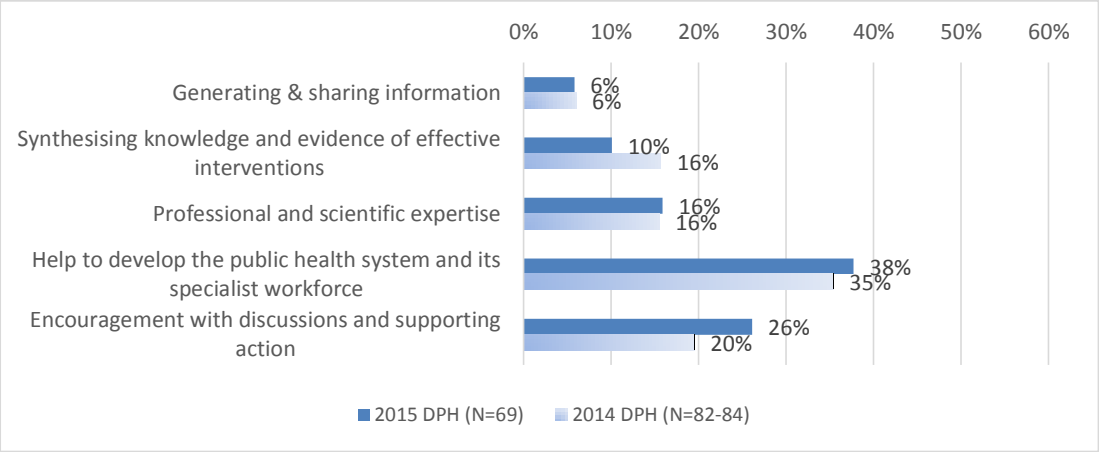
Chief Executive did not expect cuts in addition to the national 6.2% cut to the public health budget (chi-square = 5.007, df = 1, p = 0.025). The tendency for elected members to be less ready than DsPH to give a view on the extent of cuts and where they might fall, coupled with the smaller number of responses, meant that no significant variations were found on this topic in the elected member survey (although there were some similarities to DsPH in the views on cutting front line staff and protecting NHS Health Checks).

External relationships [DQ29-37, EQ17-22]

The next set of questions examined wider relationships, for example between public health teams and PHE, CCGs, and their local HWB. Some of the questions were only asked in 2014 (see DQ(32) and EQ(18) in App 3).

The survey asked about the support local authorities received from PHE. There was quite a mixed picture of small changes which brought the views of DsPH and elected members closer together, but with no clear overall improvement since the 2014 survey when the same questions were posed. The survey asked if support was received from PHE across several areas of information provision, professional and scientific expertise, development of the public health workforce and other forms of encouragement and support. Between 9-20% of DsPH and elected members said they were getting full support across these areas, and between 43-81% said 'yes to some extent'. That left up to 40% of DsPH and elected members saying they were not or not really getting support from PHE; this was particularly the case for workforce development and more general encouragement from discussions and supporting action. (See DQ29 and EQ17 in App 3 and Fig 14.)

Figure 14. In your work to improve public health, do you get the following support from Public Health England? % saying 'No or not really' (DPH surveys)



Note: the figure shows responses to several questions, and a range in N gives the maximum and minimum number answering each of the questions

When asked what value the local PHE centre added to the public health team's work on improving health and reducing health inequalities, DsPH' comments showed that there was good over-arching support and excellent support for health protection, but views on data and intelligence were mixed, with some saying it was limited or did not provide direct help with local issues. Elected members

mainly did not know or thought there was little support from PHE, but some valued the collaboration and learning opportunities that PHE had organised.

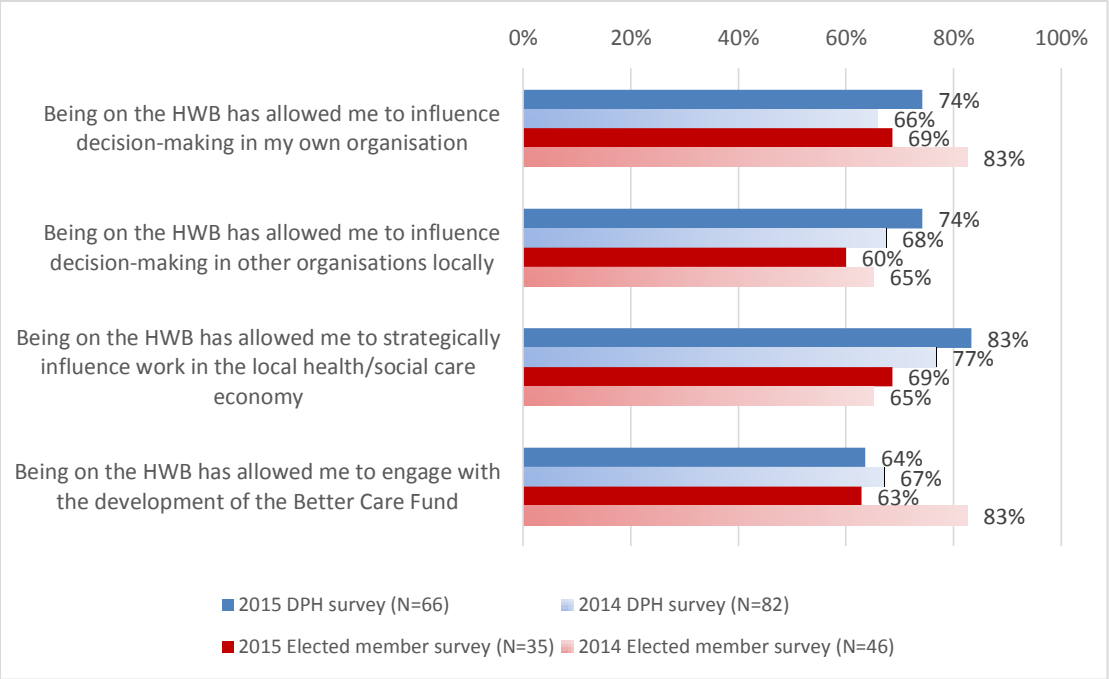
The survey asked what help they would like in the future and from whom. The majority of DPH responses stated that they would like to have a better working relationship with PHE. There was a feeling that there had been duplication of work, and that a more joined up approach would be beneficial. Responses suggested that more network support would be useful, as would more expertise in lobbying, advocacy, local policies, public health intelligence and advice on general best practice. The DsPH would also like further access to data and intelligence. Elected members again felt unable to say what kinds of future support they would like, although there were some mentions of receiving better support and collaborative working with PHE, and having improved access to data and better systems. Both of these were similar to the future support DPH respondents would like to have.

Most DsPH (96%) and elected members leading on health (97%) were members of the HWB, and this had not changed since 2014. When asked how the board was performing, the ranking of replies from DsPH and elected members was very similar, with being 'instrumental in identifying the main health and wellbeing priorities' and 'strengthening relationships between commissioning organisations' seen as the most effective aspects of HWBs. Next came 'beginning to address the wider determinants of health' and 'influencing cross-sector decisions and services to have positive impacts on health and wellbeing', even though there was an increase in the proportion of DsPH in 2015 thinking HWBs were 'not really' achieving these. In the individual authorities where we could compare 2014 with 2015, DsPH' replies for whether their HWB was beginning to address the wider determinants of health showed views on this were quite changeable as nearly a half of DsPH gave a different reply in 2015 (the reply options were 'definitely', 'to some extent' and 'not really'). Both DsPH and elected members put 'facilitating the greater use of collective budgets' and 'helping to foster a collective responsibility for the use of budgets' towards the bottom of the rankings of how HWBs were performing. At the bottom of the rankings were 'directly commissioning services' and 'making difficult decisions', although DsPH had become a little more positive about the latter. In quite a few of these areas, the upbeat and positive views we had seen from elected members in 2014 were less evident in 2015. The views of DsPH in 2015 had also shifted somewhat, as there were quite a few areas where fewer DsPH thought the HWB was 'definitely' effective, or where more thought the HWB 'not really' effective compared to 2014, for example in facilitating and fostering greater use of collective budgets and helping to identify the main health and wellbeing priorities. These findings were broadly confirmed in the authorities where year on year comparisons were possible, although as already mentioned the overall proportions imply a greater level of consistency in views than was actually seen when experience in individual authorities was tracked. (See tabular results for DQ32-33 and EQ20-21 in App 3 and 4.)

Next, the surveys asked public health leaders and elected members if their role on the HWB had enabled them to be more influential or involved within their local authority and beyond. This was another example where the results showed that the views of DsPH and elected members have moved closer (as they had in regard to the support they received from PHE). In 2015, more DsPH felt that a seat on the HWB had enabled them to strategically influence work in the local health/social care community (83% N=66 in 2015, compared to 77% N=35 in 2014); more felt it had allowed them to influence decision-making in other organisations locally (74% in 2015, compared to

68%); and more felt able to influence decision-making in their own organisation (74% in 2015, compared to 66%). Figures for elected members were slightly lower with 60-69% (N=35) saying membership of the HWB allowed them to be influential in these three areas (Fig 15), some ratings having dropped considerably since 2014. The comments showed some dissatisfaction from DsPH at the limited role and impact of the HWB, however some of the elected members felt more happy with their role as they chaired the HWB. (See also DQ34 and EQ22 in App 3.)

Figure 15. How do you see your role on the Health & Wellbeing Board?



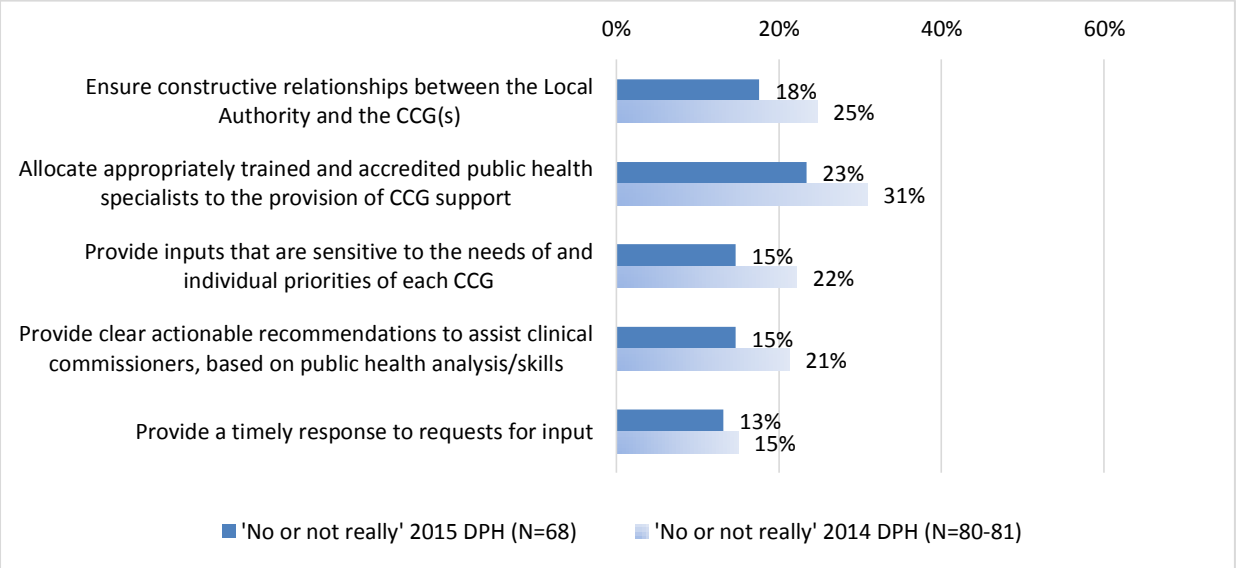
DsPH were asked about the services they provided to CCGs. The 2015 survey responses showed a small increase in the number of CCGs that the public health team supported, with 64% (down from 73% in 2014) having one CCG, 10% (unchanged) having two CCGs, and the remaining 25% (up from 17% in 2014) supporting between three and seven CCGs. (See DQ35 in App 3.)

There was an increase in the proportion of DsPH saying they had provided various kinds of support to CCGs. In the last 12 months, nearly all public health teams had provided help with planning / assessing needs (99% N=68 in 2015 compared to 100% N=82 in 2014), reviewing service provision (97% in 2015 compared to 88% in 2014) and deciding priorities (96% in 2015 compared to 85% in 2014). There had also been increases in the proportion who had helped with monitoring and evaluation (82% in 2015 compared to 73% in 2014) and procuring services (54% in 2015 compared to 40% in 2014). The comments described other services being provided, and some felt there was greater integration and a strengthening of relationships with CCGs. (See DQ36 in App 3.)

Questions on the capacity of the public health team to provide support to CCGs across a range of activities gave replies that were at first confusing, since the overall response showed some increases in capacity – fewer DsPH saying they did 'not really' have capacity and more saying 'yes – sometimes' they had capacity (see DQ37 in App 3). A different picture emerged in the authorities where we had year on year data, as the responses shifted away from saying 'yes – always' to 'yes –

sometimes' the team had sufficient capacity to support CCGs, even though the year on year comparison dataset were no different in terms of the number of CCGs they were supporting. A closer look at the overall results showed the reduction in the proportion with full capacity had also occurred but to a lesser degree, and it was concluded that the shifts had been from the extremes of the response scale towards the middle. In these questions on public health teams having capacity to support CCGs, 'sometimes' had become the more usual situation (said by 52-65% N=68 of DsPH in 2015, compared to 41-56% N=80-81 in 2014). Between 21-29% (compared to 28-32% in 2014) said they 'always' had capacity to provide the different types of support the survey asked about, and between 13-23% (15-31% in 2014) did 'not really' or 'not at all' have capacity to support their CCGs. Figure 16 shows the percentages of public health teams who did not feel they had capacity to provide these services to CCGs. Public health teams in two-tier authorities had fewer capacity issues, for example they were more able to provide appropriately trained staff to support CCGs. DsPH' comments on capacity indicated concerns for both the public health team and CCGs, and with increasing workloads and decreasing staff this would get more challenging. (See DQ37 in App 3 and 4.)

Figure 16. Is the capacity of the public health team sufficient to be able to: (DPH surveys)



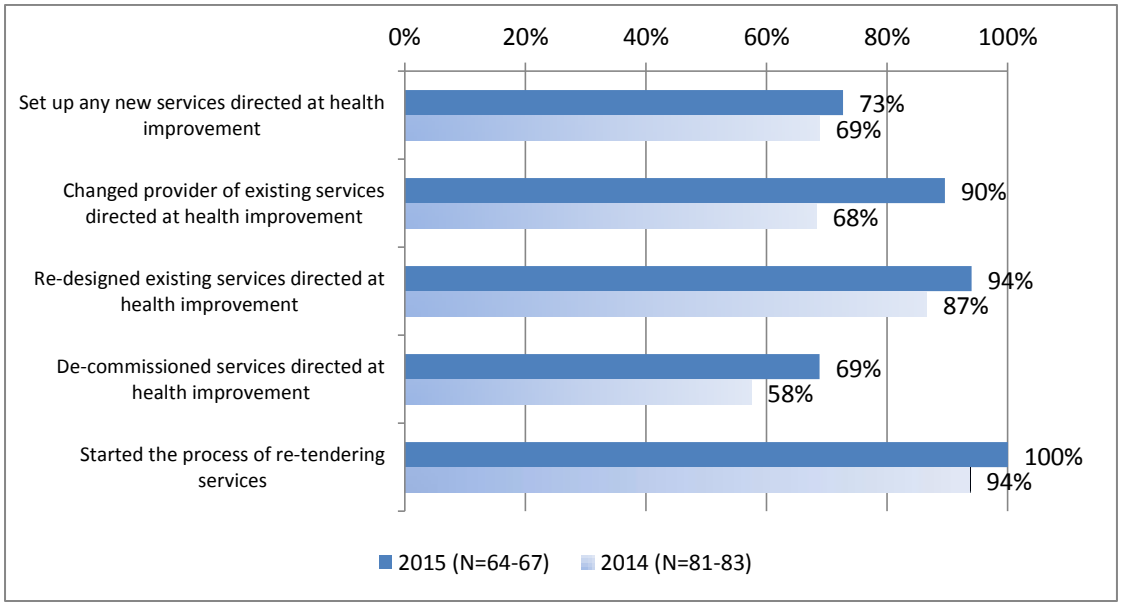
Note: the figure shows responses to several questions, and a range in N gives the maximum and minimum number answering each of the questions

Changes in commissioning [DQ38-40, EQ23-24]

When DsPH were asked if changes to services commissioned under the ring-fenced public health budget had been made in the last 12 months, the proportions who had made changes remained very high (96% N=67 in 2015, compared to 94% N=83 in 2014). Beneath this headline, the types of change the survey asked about had all occurred a lot more in the year leading up to the 2015 survey compared to that reported 2014. Re-designing existing services was most commonly reported (94% had done this in 2015, compared to 87% in 2014), and considerably more DsPH said they had changed provider (90% in 2015, compared to 68% in 2014). 73% in 2015 (69% in 2014) had set up

new services and 69% in 2015 (58% in 2014) had de-commissioned services Fig 17). The same large increases were seen in individual authorities that could be compared year on year. Comments showed that there had been major re-designing of services - for example, bringing together services into a smaller number or a single integrated contract - and that changes had occurred mainly in drug, alcohol, sexual health and smoking cessation services. (See DQ38-39 in App 3.)

Figure 17. In the last 12 months, has your local authority made any changes to services commissioned under the ring-fenced public health budget? (DPH surveys)



Note: the figure shows responses to several questions, and a range in N gives the maximum and minimum number answering each of the questions

Cross-tabulations and tests of association showed that new services were more likely to have been commissioned in authorities where the DPH was managed directly by the Chief Executive (chi-square = 5.388, df = 1, p = 0.020) and there was near significance for commissioning new services in authorities where there was a distinct public health directorate (chi-square = 5.400, df = 2, p = 0.067). Other non-significant variations were that non-metropolitan unitary authorities were least likely to have made changes in commissioning under the public health budget. Individual results that were near or non-significant are mentioned as they suggest a pattern when viewed together. There was no difference between unitary and two-tier authorities in replies on commissioning changes.

Elected members were asked if they would like to see their local authority change the way it went about improving health. The results shifted from the majority in 2014 saying 'no, I think we have got it about right', to two thirds saying they want to see change (66% N=32 in 2015, compared to 45% N=44 in 2014). Only one or two comments were made to expand on this; they suggested that public health should be mainstreamed across the authority, and that public health staff should be less territorial about how their budget was spent. (See EQ23 in App 3.)

Finally, DsPH were asked specifically about obesity and weight management services in their local authority. DsPH were asked if there had been changes in commissioning of these services in the last

12 months. Although just over a third (35% N=68 in 2015 compared to 41% N=83 in 2014) had not made changes, 35% had commissioned new services, 22% had decommissioned and 16% had made other changes to weight management services, marking a continuation of the levels of change reported in 2014. The comments from DsPH showed there had been a considerable amount of re-commissioning and re-designing of services, for example by shifting away from ineffective schemes and towards children, using new providers and 'creating a more integrated pathway'. In four authorities, DsPH said that they had re-designed or commissioned new tier 2 and 3 services. (See DQ40 in App 3.)

Elected members were asked to write in what their authority's main areas of activity were in regard to preventing obesity and improving weight management. Many indicated that they were aiming to increase levels of exercise and sport generally, and had focused their efforts on children and schools. Elected members said they were working with planning to increase parks and open spaces and reduce fast food outlets near schools, and mentioned other schemes such as weight management and healthy eating, and running broader campaigns for lifestyle change.

Summary of survey findings

Responses to the surveys in both years were reliable in terms of representing English regions, populations and types of authority. Although response rates for directors of public health fell over time in our surveys, they compared well with other national surveys, and it was possible to examine change in individual authorities, as well as presenting the overall results. Response rates for elected members in our surveys were lower but were constant over time.

Concerning the organisation of public health teams in local authorities, we had found no dominant model in 2014 and this remained the case in 2015. Most public health teams were located in another directorate such as Adult Services, with others in a distinct public health directorate. The proportion having an acting or interim DPH in post remained unchanged. However, this apparently static situation hid the fact that in around one in five authorities where we had data for both years, there had been a change in leadership, such as switching between an interim and a new DPH. A few had set up new sharing arrangements with other authorities, and for more than two in five authorities, there had been a change in the directorate in which public health was located. All this had a knock-on effect of DsPH moving on and off their authority's most senior corporate management team. For some authorities in 2015, there had been a change in the elected member holding the public health portfolio, leading to nearly a third of these being relatively inexperienced in their role. Another consequence of the transfer to local authorities has been the loss of public health staff, and despite some gains, such as commissioning/business manager posts, many teams reported they had fewer consultants and public health specialists. More change was anticipated in 2015, as nearly half of the DsPH in our survey expected more re-structuring, and that there would be changes in the size and composition of the public health team. The latter changes were seen as less likely in two-tier authorities and more likely in London boroughs.

Lines of communication between DsPH and elected members remained good, and many DsPH continued to report directly to the Chief Executive. While shifts might have been expected in the sharing of responsibilities in the year or so after re-locating to local authorities, in 2015 half the DsPH

said they had gained more areas of responsibility in the last year, and comparatively few had handed over responsibilities to other parts of the authority.

Both DsPH and elected members remained very positive about the relationships that had been built within their authority, and there were increases in how well the public health team was valued, trusted and asked for advice in the second survey in 2015. While there had been an increase in how aware other departments were of what public health staff could offer, this still remained at quite a low level. Where good relationships had developed, this translated into a greater demand for and active use of the range of services the public health teams offered. DsPH and elected members attributed successful integration of public health to the quality of staff and leadership, having wide support, including from the Chief Executive, and the merging of work streams to create more joined up working. The physical location and structure of public health teams were also mentioned as enablers, as was the identifiable public health budget. The barriers to successful integration remained the financial pressures, the mismatch between cultures and ways of working, and a lack of understanding of what public health staff do. Some fresh barriers may be emerging, seen as negative behaviours and professional tensions, which could be due to disputes around professional boundaries and a lack of clarity over roles and responsibilities.

The influence that public health leaders now have in local authorities has been assessed from our surveys by asking to what extent DsPH and elected members with the public health portfolio felt able to influence the priorities in their authority with respect to improving health. There were no significant variations across English authorities, but it was DsPH in non-London unitary authorities who felt most influential. Elected members remained more confident in their ability to be influential, and although among DsPH there was a small improvement in 2015, still only a minority felt they could always influence public health priorities in their authority. DsPH were more likely to feel influential when other factors were present, such as the public health team being well integrated and having raised its profile across the authority, the DPH having extended their areas of responsibility, and when the HWB was seen as beginning to play an effective role. Another positive factor for the impact of public health teams in 2015 was that the proportion of authorities with a requirement for other departments to collaborate with public health on their business plans had increased. The survey showed that public health teams were providing a range of services and that these were being actively used in the majority of authorities, especially population and health data and needs assessment analysis. As public health teams continued to become embedded and involved within their authority, both DsPH and elected members felt the reforms had extended their influence beyond the authority. For example, up to half of the DPH survey respondents felt more able to influence health improvements in workplaces and schools, and elected members felt more able to engage with CCGs.

With regards to budgetary responsibilities and decision-making, there remained some discrepancy between DsPH and elected members on whether expenditure from the ring-fenced public health budget was authorised by the DPH alone (most DsPH said this was the case) or not; most elected members said responsibility was either shared or in the hands of others. And within individual authorities, there was a considerable amount of change in the responsibilities of the DPH, which may have been due to structural and leadership changes affecting the public health team. Separate to the public health budget, 60-70% of DsPH and elected members said that DsPH had some influence over other departments' expenditure, but this was usually not a lot of influence (and once

again for many individual authorities the answer to this question varied between 2014 and 2015). In most authorities, the ring-fenced budget had been used to invest in other departments, and this situation had not changed over time. In the last year, as many as a quarter of public health teams had received additional funds for their work, possibly due to the added responsibilities DsPH said they had gained.

Shortly before the 2015 survey was distributed, a cut in local authorities' public health funding had been announced (Department of Health 2015), so survey responses gave an early indication of how authorities might respond. A small proportion of authorities had made a commitment to protect the budget, but around two-thirds of the respondents thought that these would be accompanied by further local cuts. DsPH were more ready than elected members to give their view, and although cuts to non-mandatory services were most likely, they were expecting cuts to all areas. Both DsPH and elected members thought that cuts were likely to be made to mandatory as well as non-mandatory services, and the comments suggested that nothing would be safe from cuts. There seemed to be some protection from deeper cuts in authorities where the DPH was directly managed by the Chief Executive and in two-tier authorities, while cuts to staff and what public health could offer were seen as most likely in London boroughs.

The surveys in 2014 had shown that support from external agencies for public health leaders in local authorities was quite limited. Most DsPH had felt there was little or no support from NHS England and the Department of Health, but that there was some support from PHE, and most considered that their local PHE centre had provided good support. In 2015, the survey showed that the majority of DsPH and elected members felt that they had received support to some extent from PHE across a number of areas such as synthesising and sharing information. Views on the local PHE centre were quite mixed, and it was often described as limited, but DsPH wanted better working relationships with them. PHE reported similar findings in their most recent stakeholder survey (Public Health England 2016).

DsPH and elected members leading on health were usually members of the local HWB and gave their opinions on how it was performing. Elected members rated the achievements of the HWB much more highly than DsPH, but there was agreement on the ranking of different aspects of the HWB's role, with helping to identify priorities and strengthening relationships between commissioning organisations appearing at the top, and making difficult decisions towards the bottom of the rankings. In 2015, HWBs were seen as getting a little better at addressing the wider determinants of health, and influencing cross-sector decisions/ services, but less good at facilitating and fostering greater use of and responsibility for collective budgets. Since 2014, DsPH had become even more positive about the value of being on the HWB - for example, in extending their influence more widely across health and social care and organisations in the community. Elected members' initially high ratings of the benefits of being on the HWB had also fallen a little in 2014.

The survey showed that public health teams had increased the level of services and support to CCGs in 2015, and that there were still capacity issues. Although capacity issues had become less extreme, the anticipated increasing workloads and decreasing staff were expected to make it more challenging to maintain the level of service to CCGs.

Changes in commissioning for health improvement had continued and even increased since 2014. While many authorities had set up new services or decommissioned old ones, by 2015 nearly all had

changed providers or re-designed existing services commissioned under the ring-fenced public health budget. Some of these had involved a major re-design of services and setting up a smaller number of integrated contracts. In 2014, changes were more likely in the authorities where DsPH felt they had most influence, and in 2015 changes were more likely in authorities where the DPH had more autonomy.

In 2015, elected members had either become more critical in their views, or we were seeing different views from the large proportion of elected members in 2015 who had recently taken on the public health portfolio, as far more wanted to see the authority change its approach to health improvement. Some of their comments suggested that despite a positive 'can do' attitude on both sides, there were still tensions and cultural differences in the approach of elected members compared to public health professionals, especially in regard to how the public health budget should be spent.

The survey showed that changes were continuing in the commissioning of obesity and weight management services, and in their comments, both DsPH and elected members seemed fully engaged in re-focusing their efforts and stopping ineffective services.

Discussion

The online surveys to upper tier and unitary authorities in England achieved a good quantity and quality of responses. Although fewer councillors than DsPH completed their questionnaires, response rates were good compared to similar contemporary studies (Association of Directors of Public Health 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. This was particularly true for the 59 authorities where there were replies to the DPH survey in both years and we could track change over time.

The transition of public health to local authorities has continued to be the focus for research since our first survey was reported. The Association of Directors of Public Health (ADPH) carried out a survey of all England DsPH in February 2015 (ADPH 2015), with many findings in agreement with of our survey, but indicating that DsPH were in a stronger position in terms of controlling the public health budget and having membership of the most senior corporate management team compared to our survey 7-8 months later. PHE had surveyed the views of their stakeholders in late 2014 and again in late 2015, which gave a wider picture of PHE's role in relation to local authorities and others and echoed some of the dissatisfaction that our surveys found with the support provided (Public Health England 2014, Public Health England 2016). A survey of DsPH and others in local authorities at the end of 2015 (Royal Society for Public Health 2015) found increasing evidence that public health was having an impact, also that DsPH had more control over their budgets in two-tier authorities where decisions were based more on evidence, compared to unitary authorities where decisions were influenced more by finance and politics. The ADPH also polled DsPH at the end of 2015 after the announcement of the in-year reduction to the public health ring-fenced budget, when DsPH anticipated reduced services spreading to all services by 2016/2017 and a detrimental impact on health and health inequalities (Association of Directors of Public Health 2016). Similar to our surveys, the ADPH survey found that drug, alcohol and smoking services were the most likely to be reduced in scope.

A round table held in late 2014 (Stopforth 2014) highlighted the difficulty of merging different structures and cultures, along with the benefits of the new location and greater scrutiny of spending decisions, which round table participants felt had led to more effective and efficient services and broader health and wellbeing issues being addressed. A survey of tobacco leads in local authorities also identified a range of views about integration, and that the positive ones - such as new relationships / opportunities and greater political support for their work - outweighed the negative impacts of transition (Anderson & Asquith 2015). Similarly, a survey of DsPH about transport and health found the benefits of being co-located, working across LA departments, and sharing data and training, represented progress despite the barriers of funding and cuts (Davis 2014).

However, other research has not taken the views of elected members in such a comprehensive manner compared to our surveys, nor has other research compared the views of public health professionals and councillors or looked at changes in individual authorities over time.

Our surveys have shown levels of change in the first two years following the transfer of public health responsibilities in April 2013. The changes varied in their speed and scale. For example, the re-structuring provided the stimulus to re-think the contracts for health improvements: being located in local authorities made a broader approach to health possible, there was a greater readiness to abandon poorly performing contracts, and consequent changes resulted in fewer contracts and more integrated services, all of which might have made commissioning more efficient and cost-effective. The picture of change was similar in the commissioning of services in the area of obesity and weight management.

The research has illustrated that while both DsPH and elected members were very positive about the new opportunities for public health, there were also many challenges, such as the turbulence of re-structuring and the merging of differing cultures and values. All of these factors occurred against a backdrop of significant reductions in local authority funding. We found no clear geographical, administrative, social or economic patterning for where the transfer to local authorities had worked well, although some variations were detected. Success was attributed to high quality leadership, demonstrable expertise of the public health team, good support from the Chief Executive, and strong managerial processes and lines of communication. There was considerable agreement between DsPH and elected members on this, suggesting that the precise arrangement or organisation of public health was not indicative of successful integration and influence of public health across the authority and beyond.

Another clear message from our surveys was that change continues to happen. The kind of changes that might have been expected in the first year were followed by more in year two, such as turnover in staff, new sharing arrangements between authorities, public health being moved around within the authority, DsPH moving on and off corporate management teams, DsPH continuing to gain more responsibilities, and so on. In addition, when looking at the experience of individual authorities over time, the survey data showed that levels of change were greater than indicated by the overall figures of 'net change'. In the near future, further restructuring of public health teams was expected in response to cuts in public health budgets, and it was anticipated that these would be exacerbated by local authority financial pressures. Cuts were envisaged to public health staff and services across the board, including mandatory sexual health services and NHS Health Checks, with drug, alcohol and smoking services being the non-mandatory services most likely to be affected. The constant

restructuring and organisational change was seen as increasingly challenging, and some DsPH were already doubtful that they had the capacity to meet the information needs of CCGs.

The views of DsPH and elected members were similar in a number of areas, such as thinking that the public health team had settled in well and had become valued and trusted. Both DsPH and elected members also acknowledged that there were cultural differences, with public health's rational and evidence-based approach compared to the need for councillors to consider the demands of politics and the local electorate. In some areas, DsPH were more critical or more pessimistic than elected members. For example, DsPH gave a low rating to the support they received from PHE, NHS England and other external agencies; they gave lower ratings for the performance of the HWB, and felt less influential and saw more barriers to successful integration compared to elected members. To some extent, though, the views of DsPH and elected members have become more similar over time.

Conclusion

Findings from the national surveys reported here showed that DsPH and elected members with the health portfolio felt that the transfer of public health to local authorities had provided opportunities for greater collaboration and integration between public health and local government departments, and as a result, public health teams have increased their influence to improve population health. The surveys showed that although public health teams were now arranged and organised in a variety of different ways, they had settled in well within their local authority. In relation to external organisations, the surveys identified some mixed views on the support to public health from external organisations such as PHE, some concerns about capacity of the public health team to continue providing high levels of support to CCGs, and views on the effectiveness of the HWBs and the benefits of being a member of the HWB. The transfer was made more challenging by the concurrent budget cuts for local authorities and it was generally accepted that future cuts would lead to further structural change and widespread cuts to services. Nevertheless, the survey data showed that DsPH and elected members largely shared the view that public health teams had transferred successfully, and cited good lines of communication, strong leadership and high quality public health staff as having been enablers for successful integration.

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Appendix 3: Frequencies and cross tabulations of national survey responses – all questions in DPH and elected member surveys in 2014 and 2015

DQ refers to the DPH survey question number in 2015 with the number in 2014 as a superscript in brackets where this differs, EQ refers likewise 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. DQ21 and EQ11.

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes – in Aug 2014	19	25.7	31	32.3
	Yes – since Aug 2014	5	6.8	0	0.0
	No [skips past next three questions]	50	67.6	65	67.7
	Total	74	100.0	96	100.0

DQ2 Please state number

		2015 frequency of new arrangements	2015 valid percent of new arrangements	2014 frequency	2014 valid percent
Valid	0	0	0.0	1	3.4
	2	3	60.0	15	51.7
	3	1	20.0	5	17.2
	4	0	0.0	1	3.4
	5	0	0.0	2	6.9
	6	0	0.0	4	13.8
	11	0	0.0	1	3.4
	12	1	20.0	0	0.0
	Total	5	100.0	29	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes, for a temporary period only	2	40.0	1	3.6
	No, it will continue	3	60.0	27	96.4
	Total	5	100.0	28	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Shared Director of Public Health (DPH) with distinct teams in each local authority	2	40.0	7	25.0
	Shared 'core' team in addition to distinct teams in each local authority	0	0.0	6	21.4
	Single shared team working across all participating local authorities	1	20.0	7	25.0

	Other (please explain):	2	40.0	8	28.6
	Total	5	100.0	28	100.0

DQ5/EQ1 Name of local authority

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Less than 6 months	5	6.8	8	8.7
	6 - 11 months	7	9.5	13	14.1
	12 - 23 months	11	14.9	42	45.7
	2 - 4 years	36	48.6	10	10.9
	5 years or more	15	20.3	19	20.7
	Total	74	100.0	92	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Less than 6 months	4	6.0	2	2.3
	6 - 11 months	2	3.0	6	7.0
	12 - 23 months	5	7.5	14	16.3
	2 - 4 years	17	25.4	11	12.8
	5 years or more	39	58.2	53	61.6
	Total	67	100.0	86	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Less than 6 months	2	4.3	0	0.0
	12 - 23 months	3	6.4	2	3.9
	2 - 4 years	11	23.4	11	21.6
	5 years or more	31	66.0	38	74.5
	Total	47	100.0	51	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Less than 6 months	8	16.7	1	2.0
	6 - 11 months	2	4.2	2	4.0
	12 - 23 months	6	12.5	8	16.0
	2 - 4 years	14	29.2	21	42.0
	5 years or more	18	37.5	18	36.0
	Total	48	100.0	50	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Less than 6 months	13	27.7	3	5.9
	6 - 11 months	1	2.1	2	3.9
	12 - 23 months	11	23.4	19	37.3
	2 - 4 years	13	27.7	18	35.3
	5 years or more	9	19.1	9	17.6
	Total	47	100.0	51	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Director of Public Health (DPH)	66	89.2	79	84.9
	Consultant in Public Health	1	1.4	2	2.2
	Other	2	2.7	5	5.4
	Acting / Interim DPH	5	6.8	7	7.5
	Total	74	100.0	93	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	48	100.0	50	92.6
	No	0	0.0	4	7.4
	Total	48	100.0	54	100.0

DQ6.1&7 combined Grade and experience (DPH)

	2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
DPH or higher with 1+ year's experience in LA	56	75.7	66	71.0
Acting/ interim/ less senior grade or DPH with <1yr in LA	18	24.3	27	29.0
Total	74	100.0	93	100.0

EQ2&3.1 combined Grade and experience (Elected member)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Cabinet/Exec member with 1+ year's experience in LA	48	100.0	49	96.1
	Not Cabinet/Exec member or with <1yr in LA	0	0	2	3.9
	Total	48	100.0	51	100.0

DQ8 In the transfer from NHS to local authority did the public health team change significantly in size or composition? – note different response options in 2015

	Directors of Public Health 2015 (2014)	Consultants/Specialists 2015 (2014)	Analysts 2015	Bus mgrs. / commissioning support 2015	Others 2015 (2014)
Smaller	4.2% (16.7%)	27.8 (29.2% / 27.6%)	9.7%	18.1%	25.9% (31.9%)
About the same	88.9% (81.1%)	56.9% (58.4% / 62.1%)	73.6%	66.7%	51.9% (47.2%)
Larger	6.9% (2.2%)	15.3% (12.4% / 10.3%)	16.7%	15.3%	22.2% (20.8%)

N=72 (54 for Others) in 2015, N=87-90 (72 for Others) in 2014

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)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Our team is not based here - it is hosted by another local authority	0	0.0	3	3.3
	Our team is a distinct public health directorate in this local authority	19	26.0	25	27.8
	Our team is a section of another directorate (please specify)	38	52.1	46	51.1
	Our team is distributed across directorates or functions, or across multiple authorities (eg virtual, hub, etc)	5	6.8	5	5.6
	We have a merged model in which public health and another local authority directorate are combined	8	11.0	5	5.6
	Other (please give details below)	3	4.1	6	6.7
	Total	73	100.0	90	100.0

DQ10.1 Are there plans affecting public health teams in the next 12 months? Does the authority plan to re-structure? - 2015 only

		2015 frequency	2015 valid percent
Valid	Yes	33	45.8
	Possibly	15	20.8
	No	22	30.6
	Don't know	2	2.8
	Total	72	100.0

DQ10.2 Are there plans affecting public health teams in the next 12 months? Do you expect change in the number of public health staff? - 2015 only

		2015 frequency	2015 valid percent
Valid	Yes	33	45.2
	Possibly	25	34.2
	No	11	15.1
	Don't know	4	5.5
	Total	73	100.0

DQ10.3 Are there plans affecting public health teams in the next 12 months? Do you expect change in the composition of the public health team? - 2015 only

		2015 frequency	2015 valid percent
Valid	Yes	33	45.2
	Possibly	20	27.4
	No	16	21.9
	Don't know	4	5.5
	Total	73	100.0

DQ10.4 Are there plans affecting public health teams in the next 12 months? Do you expect there will be new arrangements between authorities to share public health staff / responsibilities? - 2015 only

		2015 frequency	2015 valid percent
Valid	Yes	10	13.7
	Possibly	30	41.1
	No	27	37.0
	Don't know	6	8.2
	Total	73	100.0

DQ(10) 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 – only in 2014

		2014 Frequency	2014 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)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Director of Public Health	0	0.0	3	3.3
	Local Authority Chief Executive	34	46.6	38	41.8
	Other	39	53.4	50	54.9
	Total	73	100.0	91	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	39	53.4	50	54.9
	No	34	46.6	41	45.1
	Total	73	100.0	91	100.0

DQ13 Do you have direct access to elected members?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	73	100.0	88	98.9
	No	0	0.0	1	1.1
	Total	73	100.0	89	100.0

DQ(14) To which elected members do you have direct access? (tick all that apply) – only in 2014

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%

N=89 in 2014

DQ(15) comment – only in 2014

DQ14.1 (16.1) Does the DPH role cover all the core statutory responsibilities of DPHs in local authorities?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	73	100.0	84	98.8
	No	0	0.0	1	1.2
	Total	73	100.0	85	100.0

DQ14.2(16.2) Has the DPH gained additional local authority functions?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	37	50.7	30	35.7
	No	36	49.3	54	64.3
	Total	73	100.0	84	100.0

DQ14.3(16.3) Has the DPH handed over / lost some responsibilities to other parts of the local authority?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	8	11.3	20	25.3
	No	63	88.7	59	74.7
	Total	71	100.0	79	100.0

DQ14.4(16.4) Does the DPH now share some responsibilities with other parts of the local authority?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	27	39.1	33	40.7
	No	42	60.9	48	59.3
	Total	69	100.0	81	100.0

DQ15.1(17.1) Have public health staff built good relationships within the authority? (% of DsPH)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Not really	1	1.4	2	2.3
	To some extent	16	21.9	16	18.6
	Yes - definitely	56	76.7	68	79.1
	Total	73	100.0	86	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Not really	2	5.3	1	2.1
	To some extent	8	21.1	13	27.7
	Yes - definitely	28	73.7	33	70.2
	Total	38	100.0	47	100.0

DQ15.2(17.2) Are public health staff valued across the authority? (% of DsPH)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Not really	2	2.7	8	9.5
	To some extent	33	45.2	41	48.8
	Yes - definitely	38	52.1	35	41.7
	Total	73	100.0	84	100.0

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

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Not really	2	5.3	1	2.1
	To some extent	13	34.2	21	44.7
	Yes - definitely	23	60.5	25	53.2
	Total	38	100.0	47	100.0

DQ15.3(17.3) Do staff in other departments know what public health staff can offer? (% of DsPH)

	2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Not really	6	8.2	7	8.2
To some extent	48	65.8	66	77.6
Yes - definitely	19	26.0	12	14.1
Total	73	100.0	85	100

DQ15.4(17.4) Do staff in other departments ask for public health advice? (% of DsPH)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Not really	2	2.7	3	3.5
	To some extent	39	53.4	42	48.8
	Yes - definitely	32	43.8	41	47.7
	Total	73	100.0	86	100.0

DQ15.5(17.5) Do staff in other departments trust public health advice? (% of DsPH)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Not really	0	0.0	1	1.3
	To some extent	26	36.1	33	41.3
	Yes - definitely	46	63.9	46	57.5
	Total	72	100.0	80	100.0

DQ15[17] PH staff well integrated (4-5 replies in Q15 [17] = yes definitely) (% of DsPH)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	well integrated	27	37.0	26	30.2
	less well integrated	46	63.0	60	69.8
	Total	73	100.0	86	100.0

DQ16-17[18-19], EQ5-6 – comments

DQ[20] /EQ[7] Do members of the public health team sit on cross-departmental groups or committees focusing on the following areas? / EQ[7] Within the local authority, do you sit on cross-departmental groups or committees focusing on the following areas? (tick all that apply) – 2014 only

	2014 DPH survey	2014 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%

N=86 for DsPH and N=47 for elected members in 2014

DQ18[21] To what extent do you feel able to influence the priorities of your local authority? (please tick one) (% of DsPH)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Always able to influence priorities	15	21.1	13	15.1
	Quite often able	46	64.8	57	66.3
	Not often able	9	12.7	15	17.4
	Never able to influence priorities	1	1.4	1	1.2
	Total	71	100.0	86	100.0

EQ7[8] 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)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Always able to influence priorities	16	43.2	19	40.4
	Quite often able	18	48.6	25	53.2
	Not often able	3	8.1	3	6.4
	Never able to influence priorities	0	0.0	0	0.0
	Total	37	100.0	47	100.0

EQ8[(9)] 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)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Always able to influence priorities	17	44.7	20	42.6
	Quite often able	18	47.4	24	51.1
	Not often able	3	7.9	3	6.4
	Never able to influence priorities	0	0.0	0	0.0
	Total	38	100.0	47	100.0

DQ19.1[(22.1)] 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?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	More so than before the reforms	42	62.7	46	54.1
	Similar to before the reforms	19	28.4	28	32.9
	Less so than before the reforms	6	9.0	11	12.9
	Total	67	100.0	85	100.0

EQ9.1[(10.1)] 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?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	More so than before the reforms	31	91.2	42	89.4
	Similar to before the reforms	3	8.8	5	10.6
	Less so than before the reforms	0	0.0	0	0.0
	Total	34	100.0	47	100.0

DQ19.2-4[(22.2-4)] /EQ9.2-4[(10.2-4)] 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? 2015 (2014)	Influencing the work of the local CCG(s) 2015 (2014)	Influencing the work of others (e.g. local workplaces, schools) 2015 (2014)
More so….	86.6% (82.1%)	16.4% (16.7%)	49.3% (45.8%)
Similar to …	11.9% (10.7%)	35.8% (46.4%)	42.0% (45.8%)
Less so …	1.5% (7.1%)	47.8% (36.9%)	8.7% (8.4%)

N=67-69 in 2015, N=83-84 in 2014

Elected member survey	Influencing the work of the local authority as a whole? 2015 (2014)	Influencing the work of the local CCG(s) 2015 (2014)	Influencing the work of others (e.g. local workplaces, schools) 2015 (2014)
More so …	71.4% (67.4%)	58.8% (62.2%)	41.2% (52.3%)
Similar to …	28.6% (32.6%)	38.2% (35.6%)	55.9% (47.7%)
Less so …	0.0% (0.0%)	2.9% (2.2%)	2.9% (0.0%)

N=34-35 in 2015, N=44-46 in 2014

DQ20[(23)] Is there a requirement for other departments in your local authority to collaborate with Public Health on their plans? (please tick one)

	2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Yes - always	23	34.3	13	15.3
Yes - but only under certain circumstances	18	26.9	26	30.6
No	22	32.8	33	38.8
Other	4	6.0	13	15.3
Total	67	100.0	85	100.0

DQ21.1[(24.1)] /EQ10.1[(11.1)] What support does the public health team offer to others in your local authority: Provision of population and health data

	2015 DPH survey (N=70)	2015 Elected member survey (N=37)	2014 DPH survey (N=86)	2014 Elected member survey N=48)
Yes, and actively used	84.3%	70.3%	88.4%	81.3%
Yes, but not actively used	11.4%	29.7%	9.3%	18.8%
Support not supplied	4.3%	0.0%	2.3%	10.4%

DQ21.2[(24.2)] /EQ10.2[(11.2)] What support does the public health team offer to others in your local authority: Needs assessment analysis

	2015 DPH survey (N=70)	2015 Elected member survey (N=34)	2014 DPH survey (N=86)	2014 Elected member survey (N=46)
Yes, and actively used	84.3%	64.7%	83.7%	69.6%
Yes, but not actively used	12.9%	29.4%	14.0%	28.3%
Support not supplied	2.9%	5.9%	2.3%	2.2%

DQ21.3[(24.3)] /EQ10.3[(11.3)] What support does the public health team offer to others in your local authority: Monitoring health against goals or targets

	2015 DPH survey (N=70)	2015 Elected member survey (N=37)	2014 DPH survey (N=85)	2014 Elected member survey (N=48)
Yes, and actively used	60.0%	59.5%	60.0%	66.7%
Yes, but not actively used	31.4%	32.4%	31.8%	31.3%
Support not supplied	8.6%	8.1%	8.2%	2.1%

DQ21.4[(24.4)] /EQ10.4[(11.4)] What support does the public health team offer to others in your local authority: Inequalities analyses

	2015 DPH survey (N=70)	2015 Elected member survey (N=37)	2014 DPH survey (N=85)	2014 Elected member survey (N=46)
Yes, and actively used	62.9%	62.2%	54.1%	60.9%
Yes, but not actively used	32.9%	32.4%	36.5%	34.8%
Support not supplied	4.3%	5.4%	9.4%	4.3%

DQ21.5(24.5) /EQ10.5(11.5) What support does the public health team offer to others in your local authority: Support and advice for commissioning

	2015 DPH survey (N=69)	2015 Elected member survey (N=34)	2014 DPH survey (N=86)	2014 Elected member survey (N=43)
Yes, and actively used	65.2%	70.6%	69.8%	76.7%
Yes, but not actively used	27.5%	14.7%	29.1%	18.6%
Support not supplied	7.2%	14.7%	1.2%	4.7%

DQ21.6(24.6) /EQ10.6(11.6) What support does the public health team offer to others in your local authority: Other

	2015 DPH survey (N=12)	2015 Elected member survey (N=3)	2014 DPH survey (N=12)	2014 Elected member survey (N=4)
Yes, and actively used	14.9%	6.3%	12.8%	8.3%
Yes, but not actively used	1.4%	0.0%	1.2%	0.0%

DQ21(24) /EQ10(11) What support do you/ the public health team offer to others/ elected members in your local authority? % saying 'Yes, and actively used

	2015 DPH survey	2015 Elected member survey	2014 DPH survey	2014 Elected member survey
Provision of population and health data	84.3%	70.3%	88.4%	81.3%
Needs assessment analysis	84.3%	64.7%	83.7%	69.6%
Monitoring health against goals or targets	60.0%	59.5%	60.0%	66.7%
Inequalities analyses	62.9%	62.2%	54.1%	60.9%
Support and advice for commissioning	65.2%	70.6%	69.8%	76.7%
Other	14.9%	6.3%	12.8%	8.3%

See preceding tables for N

DQ(25) /EQ(12) For your area's latest Joint Health and Wellbeing Strategy, were you: - 2014 only

	2014 DPH survey (N=86)	2014 Elected member survey (N=47)
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%

DQ(26) /EQ(13) - comments – 2014 only

DQ22(27) /EQ11(14) Who authorises expenditure from the ring-fenced public health budget?

	2015 DPH survey (N=70)	2015 Elected member survey (N=35)	2014 DPH survey (N=85)	2014 Elected member survey (N=47)
Director of Public Health alone	65.7%	42.9%	57.6%	40.4%
Director of Public Health and others	30.0%	42.9%	28.2%	40.4%
Others (excl DPH)	4.3%	14.3%	14.1%	19.1%

DQ[28] When the last public health business plan was presented to the executive cabinet (or alternative), was it: (% of DsPH) - 2014 only

		2014 Frequency	2014 Valid Percent
Valid	Approved without change	42	76.4
	Approved with minor changes	13	23.6
	Total	55	100.0

EQ[15] When the last public health business plan was presented to the executive cabinet (or alternative), was it: (% of elected members) - 2014 only

		2014 Frequency	2014 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

DQ23[29] In the last 12 months, have additional funds to the ring-fenced budget been provided for the public health team's work?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	18	25.7	16	18.8
	No	52	74.3	69	81.2
	Total	70	100.0	85	100.0

DQ24[30] /EQ12[16] In the last 12 months, has the ring-fenced public health budget been used to invest in other local authority departments?

	2015 DPH survey (N=70)	2015 Elected member survey (N=35)	2014 DPH survey (N=86)	2014 Elected member survey (N=46)
Yes	88.6%	68.6%	88.4%	65.2%
No	11.4%	31.4%	11.6%	34.8%

DQ25[31] /EQ13[17] Apart from the ring-fenced PH budget, do you, or the DPH, have influence over other departments' expenditure?

		2015 DPH survey (N=70)	2015 Elected member survey (N=33)	2014 DPH survey (N=86)	2014 Elected member survey (N=44)
Valid	Yes, quite a lot	12.9%	21.2%	10.5%	22.7%
	Yes, but not a lot	48.6%	48.5%	53.5%	43.2%
	No	38.6%	30.3%	36.0%	34.1%

DQ26/EQ14 Has the council made a commitment to protect the current level of Public Health spending when the ring-fencing is removed? - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	4	5.7	3	8.6
	No	66	94.3	32	91.4
	Total	70	100.0	35	100.0

DQ27.1/EQ15.1 Do you expect expenditure to decrease in line with nationally imposed cuts? - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	51	81.0	31	93.9
	No	12	19.0	2	6.1
	Total	63	100.0	33	100.0

DQ27.2/EQ15.2 Do you expect expenditure to decrease in line with nationally imposed cuts and with further locally imposed cuts? - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	43	69.4	19	61.3
	No	19	30.6	12	38.7
	Total	62	100.0	31	100.0

DQ28.1/EQ16.1 Have you identified areas to be affected by cuts in the public health budget? Staff - front line - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	16	23.2	2	6.3
	Possibly	25	36.2	14	43.8
	No	26	37.7	10	31.3
	Don't know	2	2.9	6	18.8
	Total	69	100.0	32	100.0

DQ28.2/EQ16.2 Have you identified areas to be affected by cuts in the public health budget? Staff - back room - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	20	28.6	4	12.1
	Possibly	32	45.7	21	63.6
	No	14	20.0	3	9.1
	Don't know	4	5.7	5	15.2
	Total	70	100.0	33	100.0

DQ28.3/EQ16.3 Have you identified areas to be affected by cuts in the public health budget? Mandatory sexual health services - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	21	30.0	3	10.0
	Possibly	29	41.4	11	36.7
	No	17	24.3	11	36.7
	Don't know	3	4.3	5	16.7
	Total	70	100.0	30	100.0

DQ28.4/EQ16.4 Have you identified areas to be affected by cuts in the public health budget? NHS Health Checks - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	22	31.4	3	9.7
	Possibly	27	38.6	13	41.9
	No	18	25.7	10	32.3
	Don't know	3	4.3	5	16.1
	Total	70	100.0	31	100.0

DQ28.5/EQ16.5 Have you identified areas to be affected by cuts in the public health budget? Health Protection - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	10	14.5	2	6.5
	Possibly	21	30.4	12	38.7
	No	34	49.3	9	29.0
	Don't know	4	5.8	8	25.8
	Total	69	100.0	31	100.0

DQ28.6/EQ16.6 Have you identified areas to be affected by cuts in the public health budget? Public Health core offer to NHS - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	12	17.1	0	0.0
	Possibly	24	34.3	16	51.6
	No	31	44.3	7	22.6
	Don't know	3	4.3	8	25.8
	Total	70	100.0	31	100.0

DQ28.7/EQ16.7 Have you identified areas to be affected by cuts in the public health budget? Non-mandatory services - across the board cuts - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	22	34.4	4	12.5
	Possibly	26	40.6	18	56.3
	No	14	21.9	5	15.6
	Don't know	2	3.1	5	15.6
	Total	64	100.0	32	100.0

DQ28.8/EQ16.8 Have you identified areas to be affected by cuts in the public health budget? Non-mandatory services - but only specific services - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	23	39.7	3	11.1
	Possibly	28	48.3	13	48.1
	No	4	6.9	4	14.8
	Don't know	3	5.2	7	25.9
	Total	58	100.0	27	100.0

DQ28.9/EQ16.9 Have you identified areas to be affected by cuts in the public health budget? Cuts in other areas - 2015 only

		2015 DPH frequency	2015 DPH valid percent	2015 elected member frequency	2015 elected member valid percent
Valid	Yes	23	41.1	3	25.0
	Possibly	25	44.6	4	33.3
	No	2	3.6	0	0.0
	Don't know	6	10.7	5	41.7
	Total	56	100.0	12	100.0

DQ[32] Since the April 2013 reforms, how much support (eg advice or guidance) have you received from: (% of DsPH) - 2014 only

2014 survey	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

EQ[18] Since the April 2013 reforms, how much support (eg advice or guidance) have you received from: (% of elected members) - 2014 only

2014 survey	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

DQ29[33] /EQ17[19] In your work to improve public health, do you get the following support from Public Health England?

DPH surveys	2015 DPH valid percent (N=69)			2014 DPH valid percent (N=82-84)		
	No or not really	Yes to some extent	Yes fully	No or not really	Yes to some extent	Yes fully
Generating & sharing information	5.8	75.4	18.8	6.0	81.0	13.1
Synthesising knowledge and evidence of effective interventions	10.1	81.2	8.7	15.7	74.7	9.6
Professional and scientific expertise	15.9	63.8	20.3	15.5	63.1	21.4
Help to develop the public health system and its specialist workforce	37.7	47.8	14.5	35.4	59.8	4.9
Encouragement with discussions and supporting action	26.1	58.0	15.9	19.5	59.8	20.7

Elected member surveys	2015 elected member valid percent (N=25-31)			2014 elected member valid percent (N=35-41)		
	No or not really	Yes to some extent	Yes fully	No or not really	Yes to some extent	Yes fully
Generating & sharing information	16.1	67.7	16.1	7.3	78.0	14.6
Synthesising knowledge and evidence of effective interventions	20.7	69.0	10.3	25.0	69.4	5.6
Professional and scientific expertise	24.0	60.0	16.0	36.1	47.2	16.7
Help to develop the public health system and its specialist workforce	37.0	51.9	11.1	42.9	40.0	17.1
Encouragement with discussions and supporting action	40.0	43.3	16.7	41.5	46.3	12.2

DQ30-31[(34-35)] /EQ18-19[(20-21)] – comments

DQ32[(36)] /EQ20[(22)] Are you a member of the Health and Wellbeing Board (in the upper tier/unitary level authority you are answering for)?

	2015 HWB Member	2015 Not a HWB Member	2014 HWB Member	2014 Not a HWB Member
DPH survey	95.7%	4.3%	96.5%	3.5%
Elected member survey	97.2%	2.8%	97.9%	2.1%

N=69 for DsPH and 36 for elected members in 2015, and N=85 for DsPH and 47 elected members in 2014

DQ33[(37)] In your opinion is your Health and Wellbeing Board: (% of DsPH)

		Definitely	To some extent	Not really	N
Strengthening relationships between commissioning organisations?	DPH 2015	44.6	46.2	9.2	65
	DPH 2014	39.5	51.9	8.6	81
Facilitating the greater use of collective budgets?	DPH 2015	9.2	53.8	36.9	65
	DPH 2014	12.3	55.6	32.1	81
Helping to foster a collective responsibility for the use of budgets?	DPH 2015	14.1	46.9	39.1	64
	DPH 2014	9.9	63.0	27.2	81
Instrumental in identifying the main health and wellbeing priorities?	DPH 2015	47.7	50.8	1.5	65
	DPH 2014	60.5	33.3	6.2	81
Successfully incorporating active citizen involvement?	DPH 2015	18.5	49.2	32.3	65
	DPH 2014	9.9	42.0	48.1	81
Directly commissioning services?	DPH 2015	0.0	13.8	86.2	65
	DPH 2014	1.2	11.1	87.7	81
Making difficult decisions?	DPH 2015	4.6	41.5	53.8	65
	DPH 2014	6.2	30.9	63.0	81
Beginning to address the wider determinants of health?	DPH 2015	27.7	56.9	15.4	65
	DPH 2014	23.5	49.4	27.2	81
Influencing cross-sector decisions and services to have positive impacts on health and wellbeing	DPH 2015	23.1	67.7	9.2	65
	DPH 2014	14.8	64.2	21.0	81

EQ21[23] In your opinion is your Health and Wellbeing Board: (% of elected members)

		Definitely	To some extent	Not really	N
Strengthening relationships between commissioning organisations?	Elected member 2015	73.5	20.6	5.9	34
	Elected member 2014	77.3	18.2	4.5	44
Facilitating the greater use of collective budgets?	Elected member 2015	35.3	41.2	23.5	34
	Elected member 2014	43.2	50.0	6.8	44
Helping to foster a collective responsibility for the use of budgets?	Elected member 2015	38.2	44.1	17.6	34
	Elected member 2014	40.9	45.5	13.6	44
Instrumental in identifying the main health and wellbeing priorities?	Elected member 2015	70.6	23.5	5.9	34
	Elected member 2014	86.0	14.0	0.0	43
Successfully incorporating active citizen involvement?	Elected member 2015	11.8	64.7	23.5	34
	Elected member 2014	15.9	68.2	15.9	44
Directly commissioning services?	Elected member 2015	20.6	32.4	47.1	34
	Elected member 2014	16.3	37.2	46.5	43
Making difficult decisions?	Elected member 2015	32.4	44.1	23.5	34
	Elected member 2014	34.9	51.2	14.0	43
Beginning to address the wider determinants of health?	Elected member 2015	52.9	32.4	14.7	34
	Elected member 2014	59.1	36.4	4.5	44
Influencing cross-sector decisions and services to have positive impacts on health and wellbeing	Elected member 2015	50.0	35.3	14.7	34
	Elected member 2014	50.0	43.2	6.8	44

DQ34[38] /EQ22[24] How do you see your role on the Health & Wellbeing Board?

	2015 DPH survey (N=66)	2015 Elected member survey (N=35)	2014 DPH survey (N=82)	2014 Elected member survey (N=46)
Being on the HWB has allowed me to influence decision-making in my own organisation	74.2%	68.6%	65.9%	82.6%
Being on the HWB has allowed me to influence decision-making in other organisations locally	74.2%	60.0%	67.5%	65.2%
Being on the HWB has allowed me to strategically influence work in the local health/social care economy	83.3%	68.6%	76.8%	65.2%
Being on the HWB has allowed me to engage with the development of the Better Care Fund	63.6%	62.9%	67.1%	82.6%

DQ35[39] How many CCGs are there in your local authority area?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	1	43	64.2	60	73.2
	2	7	10.4	8	9.8
	3	7	10.4	7	8.5
	4	1	1.5	2	2.4
	5	3	4.5	2	2.4
	6	4	6.0	2	2.4
	7	2	3.0	1	1.2
	Total	67	100.0	82	100.0

DQ36[40] In the last 12 months, have you/your team provided the following services or advice to the local CCG(s)?

	2015	2014
Help with strategic planning / assessing needs	98.5%	100.0%
Help with reviewing service provision	97.0%	87.8%
Help with deciding priorities	95.5%	85.4%
Help with monitoring and evaluation	82.1%	73.2%
Help with procuring services	55.4%	39.5%
Other	16.2%	8.3%

N=65-68 in 2015, N=82 in 2014

DQ37[41] Is the capacity of the public health team sufficient to be able to:

	Yes – always 2015 (2014)	Yes – sometimes 2015 (2014)	Not really 2015 (2014)	Not at all 2015 (2014)
Ensure constructive relationships between the Local Authority and the CCG(s)	29.4% (32.1%)	52.9% (43.2%)	14.7% (23.5%)	2.9% (1.2%)
Allocate appropriately trained and accredited public health specialists to the provision of CCG support	25.0% (28.4%)	51.5% (40.7%)	16.2% (28.4%)	7.4% (2.5%)
Provide inputs that are sensitive to the needs of and individual priorities of each CCG	20.6% (32.1%)	64.7% (45.7%)	13.2% (21.0%)	1.5% (1.2%)
Provide clear actionable recommendations to assist clinical commissioners, based on public health analysis/skills	25.0% (31.3%)	60.3% (47.5%)	10.3% (20.0%)	4.4% (1.3%)
Provide a timely response to requests for input	26.5% (31.3%)	60.3% (56.3%)	10.3% (15.0%)	2.9% (0.0%)

N=68 in 2015, N=80-81 in 2014

DQ38[(42)] In the last 12 months, have you made any changes to services commissioned under the ring-fenced Public Health budget?

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes	64	95.5	78	94.0
	No	3	4.5	5	6.0
	Total	67	100.0	83	100.0

DQ39[(43)] In the last 12 months, has your local authority…

	2015	2014
Set up any new services directed at health improvement	72.7%	68.8%
Changed provider of existing services directed at health improvement	89.6%	68.3%
Re-designed existing services directed at health improvement	94.0%	86.6%
De-commissioned services directed at health improvement	68.8%	57.5%
Started the process of re-tendering services	100.0%	93.8%

N=64-67 in 2015, N=81-83 in 2014

DQ40[(44)] Have the changes to commissioning arrangements in the last 12 months led to any changes in obesity and weight management services in your local authority? (% of DsPH)

	2015	2014
No change in the level of commissioning of weight management	35.1%	40.6%
Commissioning of new services to support weight management	35.1%	34.4%
Decommissioning of previously existing services to support w	21.6%	14.6%
Other changes to the provision of weight management services	16.2%	15.6%

N=68 in 2015, N=83 in 2014

EQ23[(25)] Would you like to see your Local Authority change the way it goes about improving the health of your local population? (please tick one)

		2015 frequency	2015 valid percent	2014 frequency	2014 valid percent
Valid	Yes, I would like to see us change (please specify in the text box below)	21	65.6	20	45.5
	No, I think we have it about right	10	31.3	24	54.5
	I don't know	1	3.1	0	0.0
	Total	32	100.0	44	100.0

EQ24 – comments – 2015 only

DQ41-42[(45-46)] /EQ25-26[(27-28)] - comments

Appendix 4: Year on year change in subset of LAs that replied in both years - selected questions from national DPH surveys

Shows where change over time in the subset of authorities that replied to the DPH survey in both years gives additional information to the comparisons of all replies in Appendix 3.

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

Count

		2015			
		Director of Public Health (DPH)	Other	Acting / Interim DPH	Total
2014	Director of Public Health (DPH)	45	1	2	48
	Consultant in Public Health	0	0	1	1
	Other	2	1	1	4
	Acting / Interim DPH	3	0	1	4
Total		50	2	5	57

Although this only tells us about the role of the person replying, it does indicate there was movement between substantive DsPH and other roles

DQ6 & 7 Grade and experience

Count

		2015		
		Yes	No	Total
2014	DPH or higher with 1+ year's experience in LA	35	7	42
	Acting/ interim/ less senior grade or DPH with <1yr in LA	7	8	15
Total		42	15	57

For 25% there was change in the grade and experience of the person replying

DQ9 How is your public health team arranged in this local authority? (grouped)

Count

		2015			
		Our team is a distinct public health directorate in this loc	Our team is a section of another directorate (please specify	Other	Total
2014	Our team is a distinct public health directorate in this local authority	8	5	2	15
	Our team is a section of another directorate (please specify)	4	21	8	33
	Other	1	4	3	8
Total		13	30	13	56

A third of those who were in a distinct public health directorate in 2014 had moved into another directorate, and a few (4) who had been in another directorate had moved into a distinct public health directorate

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

Count

		2015		
		Yes	No	Total
2014	Yes	23	11	34
	No	4	18	22
Total		27	29	56

There was consistency in the person replying in 73% of authorities and change for 27% of authorities

DQ14.2 Has the DPH gained additional local authority functions?

Count

		2015		
		Yes	No	Total
2014	Yes	16	6	22
	No	11	21	32
Total		27	27	54

20% had gained additional functions in 2015 only, 11% gained additional responsibilities in 2014 only and there was no change in 69% authorities

DQ15.1 Have staff built good relationships within the authority?

Count

		2015		
		Yes - definitely	Not really / To some extent	Total
2014	Yes – definitely	36	7	43
	Not really / To some extent	6	5	11
Total		42	12	54

There was change in 24% authorities

DQ15.2 Are public health staff valued across the authority?

Count

		2015		
		Yes - definitely	Not really / To some extent	Total
2014	Yes – definitely	16	7	23
	Not really / To some extent	12	17	29
Total		28	24	52

There was change in 37% authorities

DQ15.3 Do staff in other departments know what public health staff can offer?

Count

		2015		
		Yes - definitely	Not really / To some extent	Total
2014	Yes - definitely	2	6	8
	Not really / To some extent	12	33	45
Total		14	39	53

There was change in 34% authorities

DQ15.4 Do staff in other departments ask for public health advice?

Count

		2015		
		Yes - definitely	Not really / To some extent	Total
2014	Yes - definitely	16	11	27
	Not really / To some extent	9	18	27
Total		25	29	54

There was change in 37% authorities

DQ15.5 Do staff in other departments trust public health advice?

Count

		2015		
		Yes - definitely	Not really / To some extent	Total
2014	Yes - definitely	21	7	28
	Not really / To some extent	12	9	21
Total		33	16	49

There was change in 39% authorities

DQ19.1 To what extent do you feel able to deliver real improvements in local health by: re-prioritising what you do as a team?

Count

		2015		
		more able	similar or less able	Total
2014	more able	17	7	24
	similar or less able	11	14	25
Total		28	21	49

There was change in 37% authorities

DQ19.2 To what extent do you feel able to deliver real improvements in local health by: influencing the work of the local authority as a whole?

Count

		2015		
		more able	similar or less able	Total
2014	more able	35	4	39
	similar or less able	6	5	11
Total		41	9	50

There was change in 20% authorities

DQ19.3 To what extent do you feel able to deliver real improvements in local health by: influencing the work of the local CCG(s)

Count

		2015		
		more able	similar or less able	Total
2014	more able	2	6	8
	similar or less able	4	38	42
Total		6	44	50

There was change in 20% authorities

DQ19.4 To what extent do you feel able to deliver real improvements in local health by: influencing the work of others (e.g. local workplaces, schools)

Count

		2015		
		more able	similar or less able	Total
2014	more able	13	11	24
	similar or less able	7	20	27
Total		20	31	51

There was change in 35% authorities

DQ22 Who authorises expenditure from the ring-fenced public health budget?

Count

		2015			
		Director of Public Health alone	Director of Public Health and others	others (excl DPH)	Total
2014	Director of Public Health alone	26	6	0	32
	Director of Public Health and others	5	8	2	15
	others (excl DPH)	2	1	1	4
Total		33	15	3	51

There was change in 31% authorities

DQ25 Apart from the ring-fenced PH budget, do you, or the DPH, have influence over other departments' expenditure?

Count

		2015			
		Yes, quite a lot	Yes, but not a lot	No	Total
2014	Yes, quite a lot	2	3	1	6
	Yes, but not a lot	5	15	8	28
	No	1	7	10	18
Total		8	25	19	52

There was change in 48% authorities

DQ33.1 Strengthening relationships between commissioning organisations?

Count

		2015			
		Definitely	To some extent	Not really	Total
2014	Definitely	8	10	1	19
	To some extent	9	11	3	23
	Not really	2	2	1	5
Total		19	23	5	47

There was change in 57% authorities

DQ33.2 Facilitating the greater use of collective budgets?

Count

		2015			
		Definitely	To some extent	Not really	Total
2014	Definitely	0	5	2	7
	To some extent	2	14	9	25
	Not really	1	6	8	15
Total		3	25	19	47

There was change in 53% authorities

DQ33.3 Helping to foster a collective responsibility for the use of budgets?

Count

		2015			
		Definitely	To some extent	Not really	Total
2014	Definitely	1	2	3	6
	To some extent	1	15	12	28
	Not really	2	4	6	12
Total		4	21	21	46

There was changes in 52% authorities

DQ33.4 Instrumental in identifying the main health and wellbeing priorities?

Count

		2015			
		Definitely	To some extent	Not really	Total
2014	Definitely	16	14	0	30
	To some extent	4	10	1	15
	Not really	1	1	0	2
Total		21	25	1	47

There was change in 45% authorities

DQ33.9 Influencing cross-sector decisions and services to have positive impacts on health and wellbeing

Count

		2015			
		Definitely	To some extent	Not really	Total
2014	Definitely	4	6	0	10
	To some extent	4	22	2	28
	Not really	1	7	1	9
Total		9	35	3	47

There was change in 43% authorities

DQ37.1 Ensure constructive relationships between the Local Authority and the CCG(s)

Count

		2015			
		Yes - always	Yes - sometimes	Not really / Not at all	Total
2014	Yes - always	8	10	0	18
	Yes - sometimes	4	12	4	20
	Not really / Not at all	1	5	4	10
Total		13	27	8	48

There was change in 50% authorities

DQ37.2 Allocate appropriately trained and accredited public health specialists to the provision of CCG support

Count

		2015			
		Yes - always	Yes - sometimes	Not really / Not at all	Total
2014	Yes - always	7	6	2	15
	Yes - sometimes	2	15	4	21
	Not really / Not at all	0	5	7	12
Total		9	26	13	48

There was change in 40% authorities

DQ37.3 Provide inputs that are sensitive to the needs of and individual priorities of each CCG

Count

		2015			
		Yes - always	Yes - sometimes	Not really / Not at all	Total
2014	Yes - always	6	10	1	17
	Yes - sometimes	2	16	3	21
	Not really / Not at all	0	8	2	10
Total		8	34	6	48

There was change in 50% authorities

DQ37.4 Provide clear actionable recommendations to assist clinical commissioners, based on public health analysis/skills

Count

		2015			
		Yes - always	Yes - sometimes	Not really / Not at all	Total
2014	Yes - always	6	8	1	15
	Yes - sometimes	4	14	6	24
	Not really / Not at all	0	7	2	9
Total		10	29	9	48

There was change in 54% authorities

DQ37.5 Provide a timely response to requests for input

Count

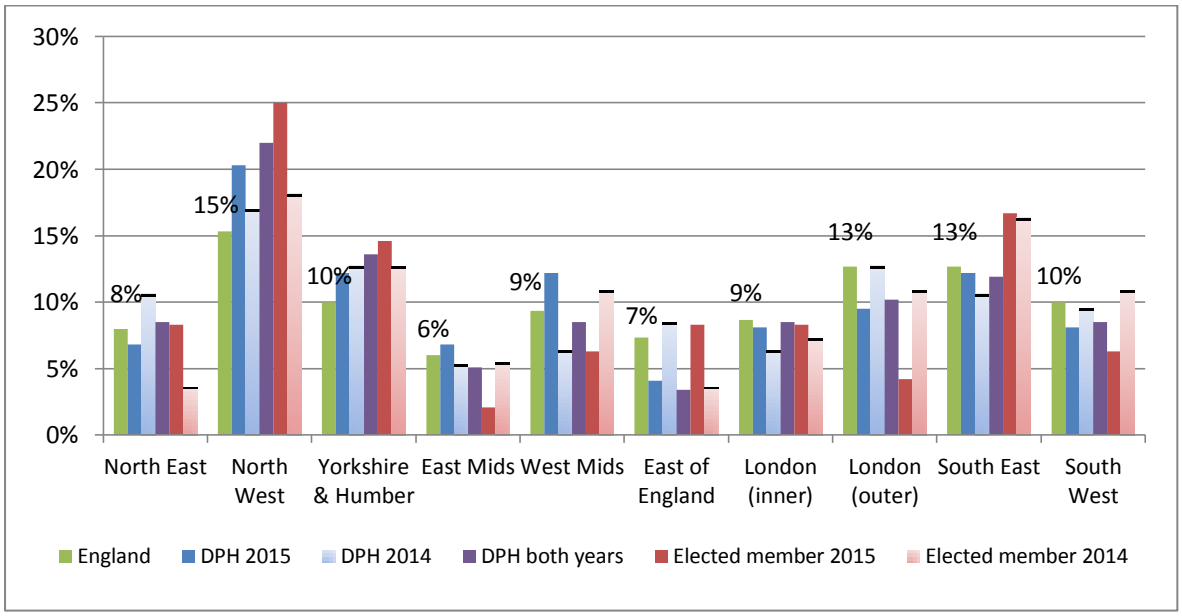
		2015			
		Yes - always	Yes - sometimes	Not really / Not at all	Total
2014	Yes - always	6	9	1	16
	Yes - sometimes	3	18	4	25
	Not really / Not at all	0	5	2	7
Total		9	32	7	48

There was change in 46% authorities

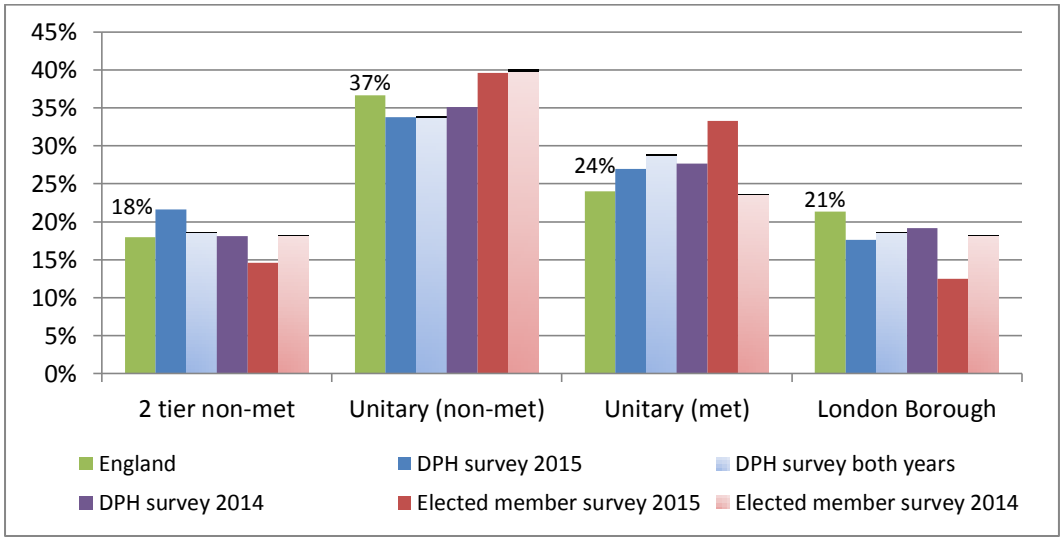
Appendix 5: Representativeness of survey responses

Comparisons of the distribution of DPH and elected member survey responses in 2014 and 2015 to all of England (figures given on the charts).

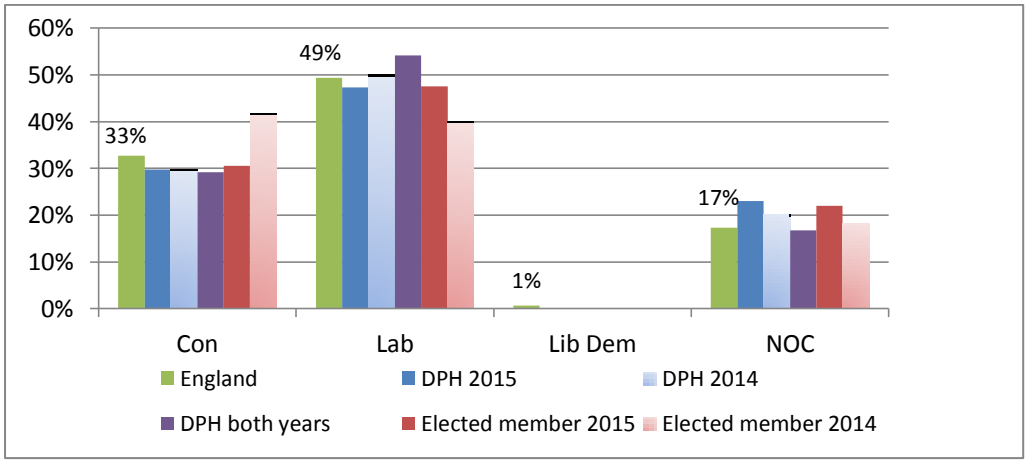
Response rates by: region of England



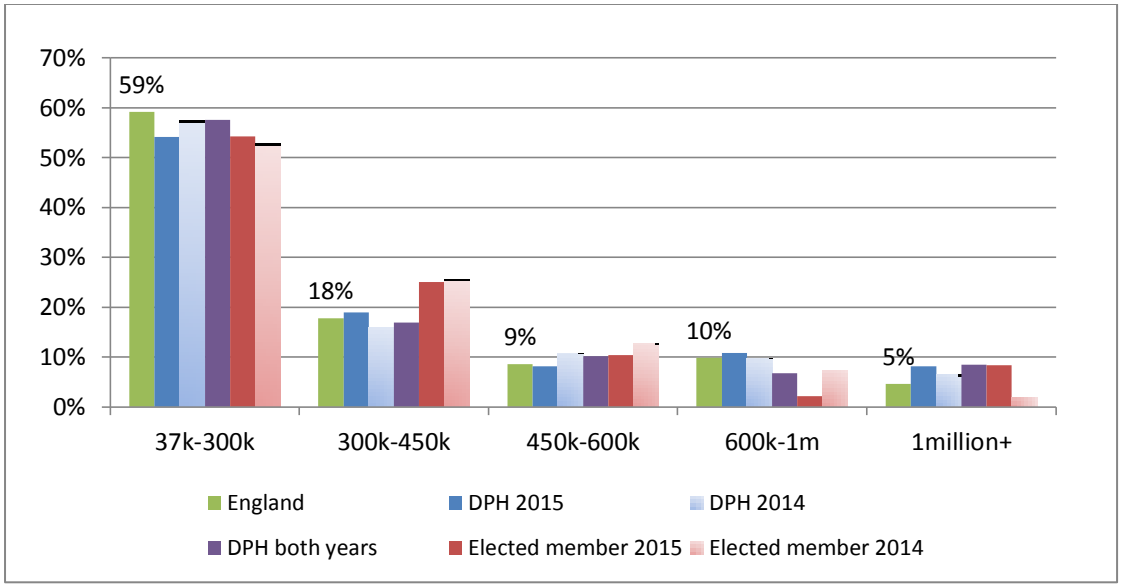
Response rates by: type of authority



Response rates by: political party in power



Survey response rates by: population size



Response rates by: PH budget (£ per head in 2013/14)