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POLICY RESEARCH UNIT IN COMMISSIONING AND THE HEALTHCARE SYSTEM

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

Second interim report
April 2015

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List of Abbreviations

CCG	**Clinical Commissioning Group**
CSU	**Commissioning Support Unit**
DH	**Department of Health**
DPH	**Director of Public Health**
DsPH	**Directors of Public Health**
HWB	**Health and Wellbeing Board**
HSCA12	**Health and Social Care Act 2012**
JHWS	**Joint Health and Wellbeing Strategy**
NHS	**National Health Service**
NHSE	**National Health Service England**
PCT	**Primary Care Trust**
PHE	**Public Health England**

1. Introduction

The PHOENIX project aims to examine the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health. This report presents the findings of our phase one case study research and first national surveys of Directors of Public Health (DsPH) and Councillors who lead on public health issues.

As part of the Health and Social Care Act 2012 (Secretary of State 2012) significant changes to the public health system were introduced. Such changes included: the creation of a new national public health service, Public Health England (PHE); a restored emphasis on the role of general practice in health improvement (DH 2010); the transfer of public health responsibilities from Primary Care Trusts (PCTs) to local authorities; and the creation of Health and Wellbeing Boards (HWBs) as committees of each unitary and upper-tier local authority, where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

As a result of the new arrangements, responsibility for commissioning and delivering public health activities are now split between a number of organisations, including: local authorities, general practice, PHE, NHS England (NHSE) (formally called the NHS Commissioning Board), and voluntary organisations. This potentially means a more complex commissioning and service delivery environment for public health than previously (DH 2011a, DH 2011b).

The shifting of many public health responsibilities back to local authorities was a generally popular aspect of the reforms, with the belief that local authorities have a strong population focus, the ability to shape services to meet local needs, the ability to influence the wider determinants of health and the ability to tackle health inequalities - all of which are much wider than health service provision.

There were many concerns around the practical implementation processes and wider ramifications of shifting public health duties and personnel to local authorities. Some stakeholders were concerned that the public health function might become weakened or fragmented – that some local authorities might be slow to realise the full extent of their public health responsibilities across health improvement, health protection and health services; that the advice and influence of public health over local National Health Service (NHS) bodies might wane; and that the public health workforce might lose their independence and ability to challenge powerful interests within local government. There were concerns too about the public health workforce and the impact of all the flux in the system created by the reform process (Gadsby et al 2014; Coleman et al 2013). Many commentators noted that whilst the changes were welcome, the timing was difficult, with the financial context for local government presenting huge challenges (LGIU 2012).

The changes brought about by the reforms are profound, with not only many potential opportunities, but also many risks. The Department of Health (DH) had restrained from being overly

prescriptive in its approach to how public health should be organised and should function within local authorities. Consequently, the functioning of the public health system taking shape since April 2013 is an important focus for research. Our initial scoping review and associated analysis of the Select Committee report into the role of local authorities in health issues (Riches et al 2015), identified a number of key areas that provided a framework for the current phase of this research. These related to the governance and accountability mechanisms for public health, local decision making processes, different ways of working and the need to develop new relationships to work in a more fragmented public health system (Gadsby et al 2014). In order to explore these questions our research objectives were:

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

This second interim report summarises the preliminary findings of the case study research which commenced in March 2014 (but which continues throughout 2015) and national surveys of both Directors of Public Health (DsPH) and councillor leads for public health undertaken in July 2014.

2. Methods

The study incorporates multiple methods, including key informant interviews, document analysis, local case-studies and national surveys. We conducted an initial scoping review in the first nine months (from April 2013) which we used to frame the focus of our data collection in subsequent case study research (Gadsby et al 2014). We began the case study phase of the research in March 2014, following the recruitment of case study sites. We are also conducting two annual national surveys of Directors of Public Health and Councillors with a responsibility for public health in the 152 English unitary and upper-tier authorities: the first survey was undertaken through July/August 2014 and the second is due in September 2015. The focus was on exploring the impacts of structural changes at national, regional and local levels on the planning, organisation, commissioning and delivery of health improvement services. The aim was to examine these broader relationships in order to capture different organisational arrangements in local government and the NHS.

In addition to examining the wider structures and organisation of public health at a local level, we are examining the process of commissioning and delivery using obesity as a tracer topic. In the second phased of case study work (commencing in March 2015), we are particularly interested in examining the response of local public health systems to obesity, as an example of a 'wicked problem' (Rittel and Webber 1973, Hunter 2013): the approaches taken by key actors; how commissioning decisions are made; what the resulting spectrum of services/activities looks like; and whether there is any change in the balance of services commissioned or carried out, ranging from individual-level clinical services (such as surgery) to high-level upstream population approaches.

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

In five sites, we were able to begin discussions and data collection in March. While the recruitment/access issues were being dealt with, it became clear in the authorities that we were working in that the public health organisational landscape was evolving quickly and becoming even more complex. We quickly identified a range of complex joint arrangements for public health. In county case studies, the important role of district councils was immediately obvious. We felt it was imperative that the research captured this aspect of the new system and explored the district/county council relationships. In other case study sites there were a range of organisational arrangements between authorities including joint appointment of DPHs, shared public health teams, formal inter-authority collaborations and agency arrangements where one local authority acted on

behalf of another. These are not all discrete developments with some case study sites displaying a number of different relationships. In addition to these inter-authority relationships, each case study has a range of differing relationships with CCGs, service providers and regional and national public health and NHS agencies.

This complexity is important in terms of exploring relational and organisational issues and how local authorities develop their commissioning and delivery systems for public health. As a result, it was decided to focus our research on five case studies and develop a more in-depth exploration of these areas to include relevant adjacent authorities and the broader context within which public health was developing in these areas. This has resulted in the inclusion of a sample of district councils within county council areas, adjacent unitary/county authorities where there are shared services or formal/informal relationships, extended data collection to the supra-network and the inclusion of adjacent authorities sharing a DPH. Within our five case study areas, we have included nine upper-tier or unitary authorities, and a sample of four lower-tier councils. In each case study area, the focus has remained on the initial council, but with additional interviews in the other authorities to explore the organisational relationships and collaborative approaches being developed. This approach has enabled a much richer analysis of current developments related to organisation of public health and a clearer picture of the emerging public health system structures to be identified. The change in case study sites is shown in table 1.

Table 1: Proposed and final case study sites

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

2.1 Case study descriptions:

Site A:

This site encompasses a large two-tier council, with multiple districts and CCGs. The upper-tier council is Conservative-run, covering a heterogeneous population that as a whole is within the least deprived third of authorities (in England), but which contains pockets of severe deprivation. The

county council is run by a leader and a cabinet, who together comprise the 'executive', and who appoint a corporate management team representing the main directorates. The HWB is chaired by a cabinet member and includes elected members from three of the county's districts.

The public health team transitioned into the Council in 2011, although the DPH had been a joint appointment for several years before that. The team are located in one place in the council, as a separate department. However, in recent re-organisations, that department has now been situated within a new social care, health and wellbeing directorate. The public health team are organised by function, but have a nominated consultant lead for each CCG - each CCG area also has a local HWB, a specialist lead for each district council, and leads for each county council directorate. Due to the importance of local links and geography, data collection has been expanded to encompass a neighbouring unitary authority, and a sample of two district councils.

Site B:

This site focuses on an urban borough council with a Conservative majority. The borough has a relatively young, relatively healthy population (compared with England as a whole), but areas of great affluence sit alongside pockets of deprivation. Due to financial pressures, the council has combined specific areas of service delivery with neighbouring councils. Public health is one of those combined services, being hosted by one borough, but working across the other boroughs. The council is run by a cabinet, supported by a chief executive and other strategic directors who together form the Strategic Executive Board. The public health team is located in one place, and are structured according to function. They have one strategic DPH and three Deputy DsPH. The team were initially placed within the Chief Executive's division, but have recently been moved into the Adult Social Care Services directorate. There is a separate HWB in each of the boroughs. Due to the nature of the sharing arrangement, whilst our focus is on the one borough chosen, we are expanding our data collection, to some extent, to include the other boroughs.

Site C:

Site C is in the north of England and is ranked very highly in terms of overall deprivation. It is particularly disadvantaged in relation to employment, income, education, skills and training. The council is Labour-led and has two parliamentary constituencies. The DPH reports to the chief executive in the council and the public health team are in a community orientated directorate, encompassing adult social care, education, children and families, among other responsibilities. The site was linked to one CCG that has now merged with a neighbouring, larger CCG. The HWB is chaired by a councillor and was previously chaired by the council leader.

Site D:

Site D is a two-tier county council. There are a number of district councils in the lower tier. This is a Conservative-led council with a leader and cabinet, and five departments overseen by a chief executive. The HWB is chaired by the lead member for health and two district councillors sit on the HWB to represent all district council interests. Income levels are generally above the national average, but there are pockets of deprivation within the county.

Each of the districts has their own non-statutory HWB partnership groups. The county council works closely with the neighbouring city council, and with a small neighbouring unitary authority, where

the county public health department acts as an agent for the council. These three local authorities have a joint health overview and scrutiny committee to scrutinise the work of the health services that work across the three authorities. Data collection has been extended to take account of these important links. There are two CCGs, one of which crosses the county border with the neighbouring small local authority mentioned above.

Site E:

Site E is a unitary authority in a large city with high levels of deprivation which are almost universally above the national average across the city. The authority is Labour-led with no major opposition. The council operates a committee structure, with the Executive as the principal decision making body. The leader of the Executive is also the chair of the HWB. This is supported by senior officers, one of whom is the DPH.

There is on-going restructuring within the council and there will be a directorate of people, bringing together adults' and children's services, and a directorate of place to deal with planning and regeneration. Public health works across these areas and is not a clearly defined separate team. There is a small core public health team that works with the DPH. There are multiple CCGs and the city is served by a number of hospital trusts. There is a successful collaborative network that works across the local authorities in the region, on behalf of the DsPH. Data collection has been extended to examine the role of this group.

2.2 Data collection to date:

To date, we have conducted 51 interviews in our case study sites. In addition we also observed 11 meetings across the five sites and collated a wealth of supplementary documentary data which contributed to how we developed the themes for analysis. The interviews and observations focused mainly on the broader organisational and relational issues. The first survey consisted of a web-based questionnaire sent to all DsPH (and, where groups of local authorities shared a DPH, to the senior public health consultant in each council) and to councillors who had a public health brief (normally the cabinet member or executive lead). We achieved a good response for the DPH survey with 97 responses (93 usable replies, response rate 61%); and for the councillor survey, we received 56 responses (52 usable, response rate 35%). Given the descriptive nature of the research, the threshold for a 'usable' response was set low, and all replies were kept if they supplied information we did not already know. One DPH (responsible for three authorities) opted out of our survey, and three cabinet leads had already opted out of doing any surveys utilising the Survey Monkey platform. Overall we received at least one response from 115 local authorities (76%), and have both DPH and elected member perspectives in 34 (22%) authorities. There was a reasonably representative spread of DsPH responses across England in terms of region, type of authority, party in power, population size and public health budget per head. The same was true for elected members, apart from there being more replies than expected from London boroughs and less from non-metropolitan unitary authorities. Fuller details of the survey and descriptive statistics are discussed in a separate report (Jenkins et al 2015).

2.3 Data analysis

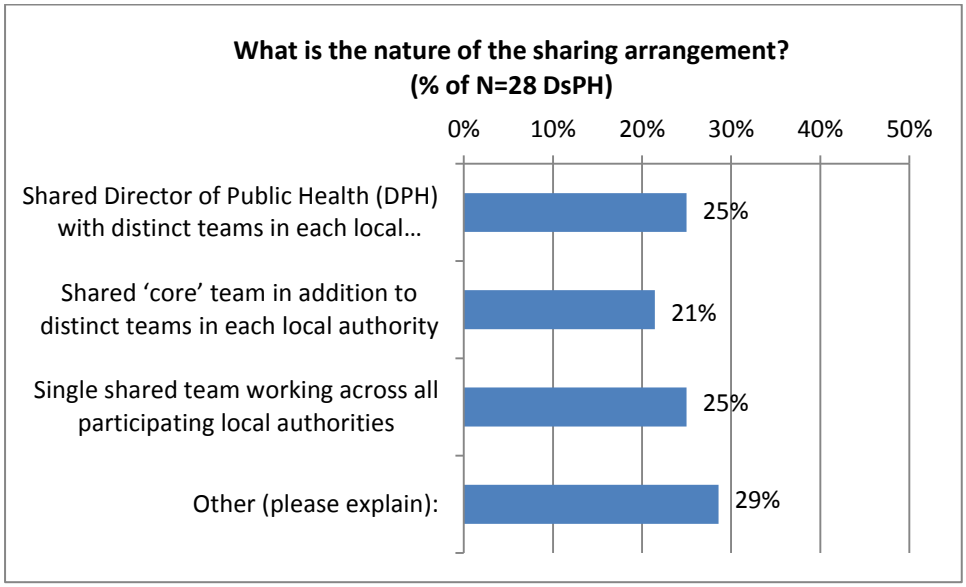
All interviews were recorded and transcribed. Data has been coded and analysed (using NVIVO 10) for key themes. The focus and themes for analysis were drawn from the data and discussed within the research team. For this report we are presenting data on the organisational arrangement for public health within local authorities and relationships within the local public health system. Data from the surveys has been incorporated where relevant. Data from observations of meetings and documents has been used to both contextualise our data collection. Within this report we have used generic titles for interviewees and only made specific reference to case study sites or titles when needed for clarification. This has been done to ensure, as far as possible, that we maintain the anonymity and confidentiality of interviewees.

3. Findings

3.1 Organisational Arrangements for Public Health

The government gave little prescription about how the delivery of public health should be organised within local authorities, although statutory responsibility and employment of DsPH lie with upper-tier county councils and unitary authorities. In *Healthy Lives, Healthy People* (DH 2010) the government recognised that in fulfilling their public health function, councils could work together, sharing the role of DPH (DH 2010: para 4.9) and leaving local authorities *"… free to take joint approaches to public health where they think that is the best way to tackle health improvement challenges that extend beyond local areas."* (DH 2010: para 4.16). We have found that many councils are sharing public health staff and responsibilities. Of the 93 DsPH responding to our national survey, nearly a third (N=31) led public health teams providing services for between two and eleven authorities. When asked about the nature of the sharing arrangements not all replied, but those that did showed an even spread across different models, with 'other' arrangements covering a mixture of core and local team responsibilities, including co-commissioning or using one of the public health teams for a specific service (See figure 1).

Figure 1: Nature of local authority sharing arrangements



The degree and complexity of sharing was evident in our case studies. In some cases this was formal, with contracted shared services or agreements supported by memoranda of understanding, while in others, respondents referred to informal arrangements – for example, attending CCG meetings where the CCG covered more than one council. In one of our case studies (Site E) public health arrangements mirrored other inter-council organisational structures which had been previously developed and in another (Site C), some services (such as Tier 3 weight management services) were jointly commissioned across six unitary authorities. Over half (48/90) of our DPH survey respondents reported some form of inter-authority sharing arrangements between public health teams. Strategic alliances and joint-working were particularly common in larger metropolitan areas. However, there

were also examples of where some authorities supported the work of smaller authorities with responsibility for public health.

3.2 Arrangement (and size) of the public health team

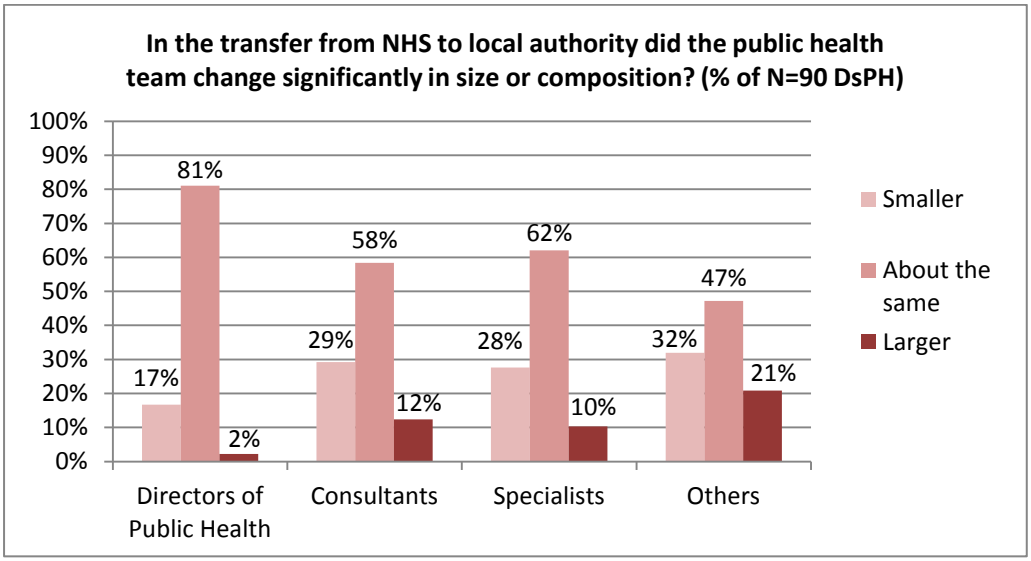
In its public health white paper, the government stressed the importance of local democracy and autonomy within the new public health system, and accepted that "There are various models for how effective public health services can be delivered, and it should be determined locally as to how particular areas make their arrangements." (DH 2010 para 4.21).

Our survey showed that for most public health teams, there was a substantial transfer of staff from the NHS to local government. In some areas though, there were already joint appointments or other cross-working arrangements for certain public health staff members. Also, in the lead-up to and during transition, some public health staff left or were transferred to other bodies. One public health team member explained the process prior to transfer in their site:

> *"each employee of the PCT was asked to complete a form looking at their portfolio and what their responsibilities were and if... and there was like a 50% threshold or cut-off whether you would remain... whether you would go to the CSU - which is the Commissioning Support Unit supporting the CCGs - or, you know, whether you go to local authority or to some other part of the system, like NHS England or Public Health England, depending on the portfolio that you were managing"* (Public health commissioning manager).

Respondents to our DPH survey reported that in most cases teams remained the same or were made smaller (See figure 2).

Figure 2: Changes to public health team size and composition



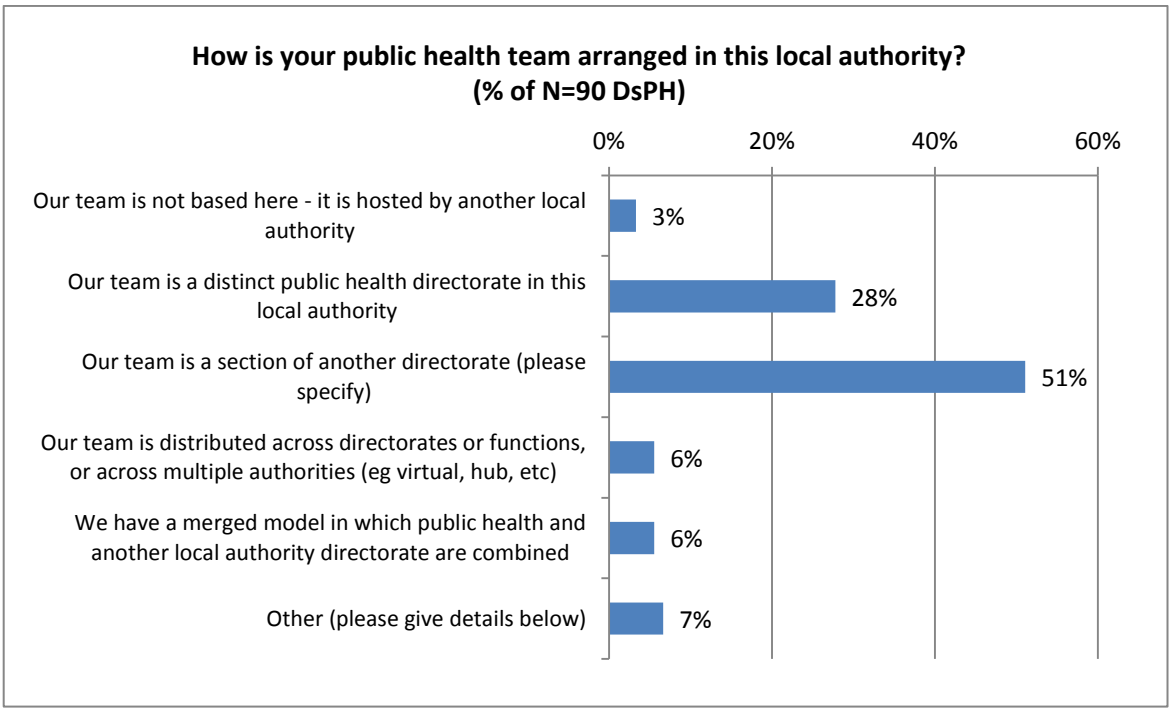
However, other councils reported a growth in staff – particularly for other, non-specialist public health roles. In one of our case study sites, there was a specific 'workforce development' post created, *"because we had quite a clear remit from the Chief Executive to... to go and enthuse the*

local authority into public health" (public health consultant). This and one other or our sites had also recruited more staff to bolster their business / strategic planning and commissioning support roles.

As in our scoping review we found that there was a degree of organisational turbulence within public health teams due to both a continuing re-organisation of public teams but also broader local authority wide restructuring. Following the complex transfer of staff, the majority of our sites have also seen subsequent changes to structures within the local authority which were continuing. Respondents in our case study sites discussed at length the problems associated with transferring staff and bedding down public health within new organisational arrangements. This was especially complex where multiple teams were merging to provide a service across larger geographical areas (e.g. across a whole county, or across multiple councils). However, for many respondents organisational restructuring remained a continuing issue.

Local authorities are generally composed of directorates (and/or departments/divisions). How these are organised, and where public health sits in these arrangements, can make a difference to how things operate and for the (perceived) status of public health and the DPH within and outside a local authority. Our survey data identified a variety of internal organisational arrangements for public health teams, as shown in figure 3. The most common arrangement for public health (51%) was to remain together as a team but be placed within another directorate.

Figure 3: Organisation of public health teams within local authorities



3.3 Position of public health staff within the council

Prior to the establishment of the new system, concerns were expressed about the position of the DPH and their relationship with the council. Many commentators felt that the DPH should be sufficiently senior that they would have the autonomy to hold other areas of the local authority to account if necessary (HCLGC 2012; Riches et al, 2015).

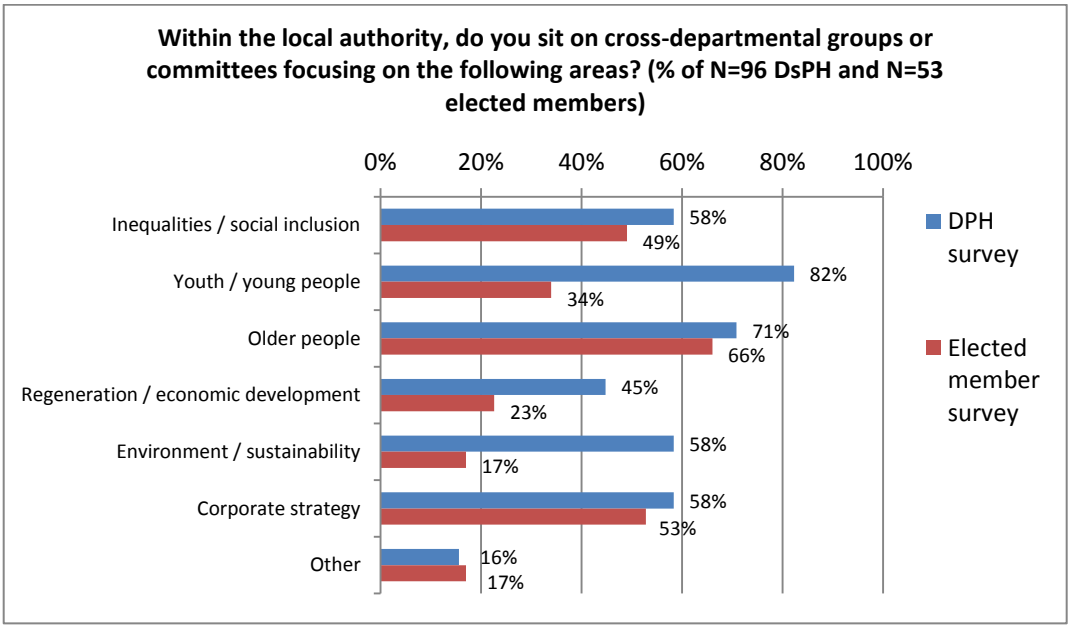
In our case study sites, reporting lines from public health (via the DPH) to the chief executive were seen as important. This reflected (perceived) standing/importance given to public health and was thought to affect the perceptions of others (within and from outside the local authority) about how important the role of the DPH and public health more widely was. It was also felt to be important what local authority fora/groups the DPH was invited to (management and strategic), in terms of voice and visibility throughout the local authority.

> *"I report to the Chief Executive and I attend the corporate team when there's an issue. I'm not around the table at every single meeting … but I'm grateful for that…"* (Director of public health).

> *"The Public Health Director is trying to make sure that that is encouraged by being on the senior management team and all that stuff, it starts to implicate and infiltrate" (Leader of the council).*

In one of our sites a cross-council public health board meeting had been established to try "*to give some focus across all of [the council] to pick up the public health agenda"* (Councillor). As shown in figure 4 the survey showed that DsPH, and to a lesser extent elected members holding the health portfolio, sit on a number of cross-departmental groups within their authority.

Figure 4: Membership of cross-departmental groups or committees



Responses to the DPH survey demonstrate that public health teams are located across a wide range of local authority directorates including as a stand-alone department or within adult and children services/social care; neighbourhood and community services; people and communities, adults, housing and health; culture, community and economic development; as well as the chief executive's department. At the time of our survey, 28% of DPH respondents were in a directorate of public health and 42% were managerially responsible to the chief executive – similar figures to those found by the Association of Directors of Public Health (ADPH 2014).

This diversity of organisation was reflected in our case study sites. In two sites (A and B), the public health function transferred into its own directorate, with direct line to the chief executive/head of paid service, to then be subsequently moved into a directorate responsible for social care. This raised some concerns for the public health consultants involved, particularly around the budget/function being subsumed or lost within a much larger (more expensive) directorate, and around the difference in population perspectives:

> *" There is a risk that we'll be seen to be silo'd back into social care…"* (Public health consultant).

> *"Because public health is actually small fry compared with the budget that social care has and therefore my concern is that does mean that the prominence of the work that we do is therefore not as great"* (Public health consultant,).

> *"they said 'line management by social care' and I said 'why?' […] social care deals with less than 5% of the population so it's not a natural home…"* (Public health consultant).

In one site (E) public health was transferred into a more diverse directorate, following a whole-council restructuring, and in another site (D) it was in a directorate of its own.

> *"We've been made our own directorate and we're actually a very small directorate compared to some of the enormous adult and children's services […] So I think the fact that we're classed as the directorate within the County council is a very positive move"* (Senior public health manager).

On-going change has been evident in most of the sites (in terms of directorate form and function), especially as the local authorities receive yet more budget cuts. The process of developing and integrating new functions at the same time as dealing with pressures and cuts within local authorities has been a clear challenge. There is every indication that this is likely to continue in the future:

> "*One of the big pushes nationally, within local government, is to be slimmer - less money, less staff, obviously, and have less directorates"* (Director of public health).

This, in some cases, has proved confusing to those working as part of public health, and was causing some uncertainty and extra disruption - as illustrated by the following respondent:

"I mean, my job title doesn't mean anything now […] The reality is when you come into work each day, and somebody asks you to do something, you do it basically. And you find a way of working round it […] then you find an imaginative way of doing it, despite the structure, so despite your job titles, and despite who you are reporting to" (Local authority manager).

Amongst our interviewees, there were seen to be advantages and disadvantages to either having the public health team spread through the local authority, or kept as a close team:

"Because once you disintegrate public health and put them… distribute them across an organisation, there is no critical mass and I think then, the impacts public health can have would become diminished" (Public health consultant).

"So I've positioned public health so that we can stay as a specialist team, we link strongly into other bits of the system […] where some of our functions are best placed in other bits of the council, then we've created functions in other bits of the system, so for example, some of the performance monitoring we need around public health, contract monitoring for our commissioned services […] so they are not sitting in the public health team. So in that sense it's a hub and spoke" (Director of public health).

Public health did not always sit well within defined directorates with more specific responsibilities. In particular, councils tend to organise member involvement through committee or cabinet member areas of responsibility. It was recognised that public health did not always fit to committee structures and that other committees beyond the HWB are relevant for much public health work. One respondent described the importance of a specific associated cabinet role which includes health and public health so that it is seen clearly on the council's agenda, as well as helping to secure political support:

"I wanted to make sure we had a lead cabinet member for health, as we called it. So, public health, and what else we expected to come along, was not just going to be lost in that social care, and I believe that strongly […] but I believe that the separation of public health and health, from social care, in terms of a successful transition and giving the right prominence to the role, in the local authority was really important, so that's what we did. And I got political support for that" (Chief executive).

3.4 Position of public health staff within the local system

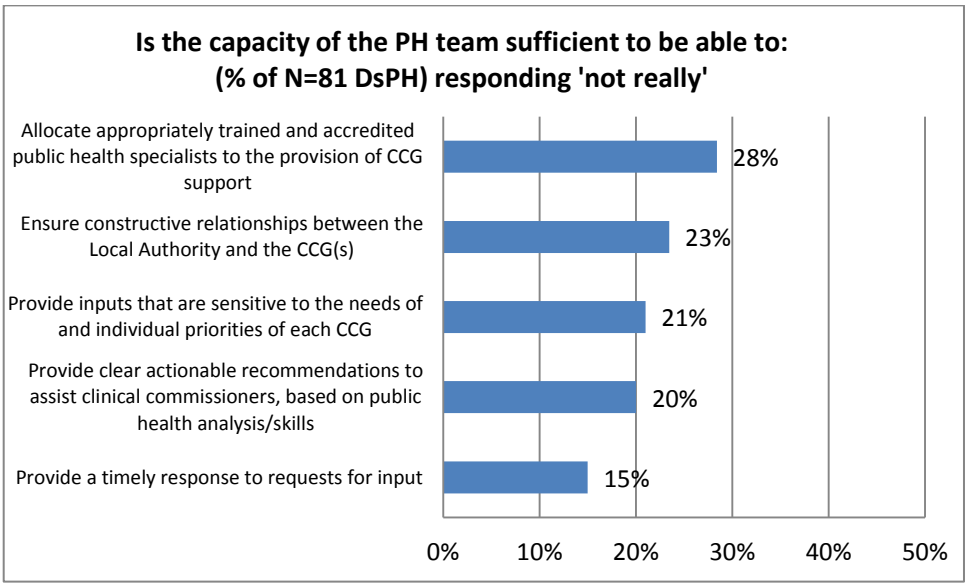
Public health was seen as a function that crossed many organisational boundaries. The public health teams in our case study sites were developing relationships across multiple organisations within their local systems. Each public health team has a duty to provide support and advice to the CCGs in their area, and this was done by having nominated public health consultants linked to each CCG. Key people were seen to be attending each other's meetings – for example, the DPH being on the CCG board. In one of our sites, the public health representatives on the three CCGs attended weekly management meetings. There was seen to be joint working on a number of initiatives, and aligned and sometimes joint commissioning. Whilst relationships with CCGs in all our sites were reported as

being productive, they had been challenged throughout the transition process (particularly with regards to sorting out budgets (see section 3.5 on resources). They also have been, and continue to be challenged by the capacity (in terms of staff time) of the public health team – particularly where the number of consultants is few compared with the number of CCGs. Nearly three quarters (73%) of the DsPH replying to the survey worked with one CCG, 18% worked with two or three CCGs, and the remainder worked with between four and seven CCGs. While our survey suggested that DsPH were positive about the help the public health team provided for CCGs, especially help with strategic planning/assessing needs (100%), reviewing service provision (88%) and deciding priorities (85%), our case study respondents referred to the problem of high expectations of CCGs

> *"we have a memorandum of understanding that was drawn up [with the CCGs] before we moved and then it was tweaked, but the amount of work that's incorporated within that, it would take your whole... all your work"* (Public health consultant).

When asked about capacity to provide various services to CCGs, between 28-32% of DsPH said the public health team always had sufficient capacity, and very few said they did not at all (0-2.5%). Although the majority of replies (41-56%) were a qualified 'yes, sometimes', there were sizeable proportions saying they did 'not really' have sufficient capacity to provide services as shown in figure 5.

Figure 5: Capacity of the public health team



However, there was variation in capacity between authorities with only 13% of DsPH in London boroughs of the opinion that their public health team 'always' had sufficient capacity to ensure constructive relationships, allocate appropriately trained staff and provide actionable recommendations to CCGs (significantly different at 95% confidence level). In contrast, 57% of DsPH working with many CCGs felt there was 'always' sufficient capacity in these areas (not statistically significant as only seven DsPH were working with four or more CCGs).

In two-tier councils, another important relationship is between the public health team and the district councils. Whilst the role of district councils in the public health function are well recognised, there was little thought given prior to the reforms as to how and to what extent public health staff would relate to district councils. Whilst public health interviewees reported having worked with district councils in the past, it was clear that in the new system, this relationship had been strengthened. As illustrated by this public health consultant:

> *"…we have this health lead, district health leads meeting, where they have a nominated person from each district who is responsible for sort of health and wellbeing. And they come together, and they meet with people from public health, and I'm now the sort of lead for that. To talk about how we can work better together. And we've come up with a system which is now much more inclusive, and open, in terms of how they can influence the whole of our commissioning process…And I think since we've done that, and had that open conversation, relationships are much improved, I would say".*

As illustrated above, in case study sites A and D, each county arranged its public health team to interact closely with district councils, with named public health specialists for each district, although in the larger county (site A) it was clear that resources were stretched thinly across more than ten districts. One leader of a district council in site A felt that the link between the council and the public health team was now much stronger following the reforms:

> *"Well we're more public health... we're more public health oriented because we've got a public health professional sitting amongst us who's identifying some of these things and saying, 'well we can do things. We can allocate some sums here. Do you want to be part of it?'"* (Leader, district council).

In both our county sites, due to the large number of district councils, not all could be represented on the county-level HWB. However, both had representative district councils on the board, and in both counties there were local versions of HWBs – in site A, these were designed to match CCG boundaries, so all the district councils sit on at least one of those local HWBs, and in site D, there was one local board for each district council. All the local HWBs had a dedicated public health specialist as member. In addition, in site A, each local HWB had an integrated commissioning board, which is attended by a member of the public health team (e.g. business manager or commissioning manager). This is to ensure commissioning is aligned and integrated where possible at a local level.

HWBs were seen as important for public health despite their broader function and current strong focus on integrated care. The DPH is a statutory member of the HWB but there were different expectations about how engaged HWBs actually were, or should be, with the wider public health agenda:

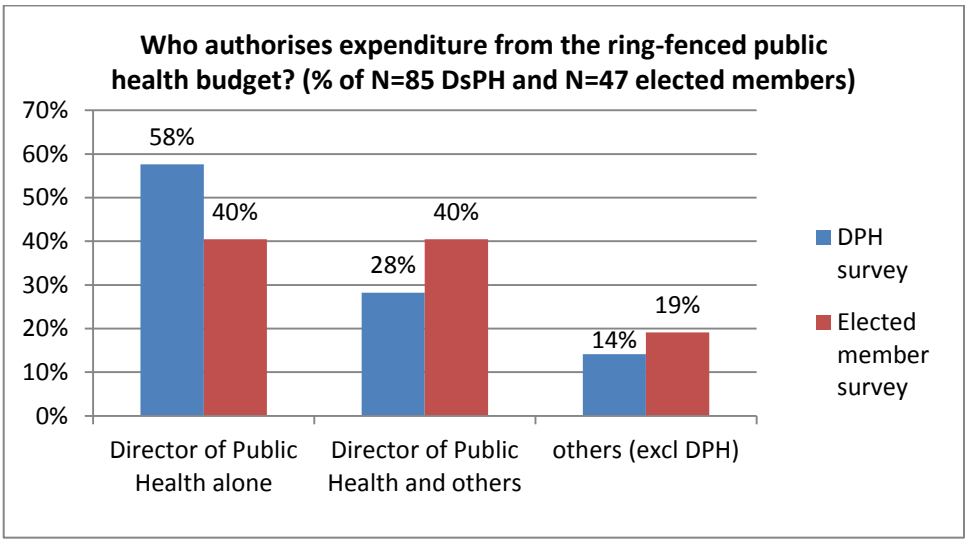
> *"We have a very strong focus on integration, Better Care Fund – all that side of things. I'm conscious sometimes of an element of criticism. Well I mean when I say criticism it's probably a bit strong; there's always a challenge to say, 'Are you actually thinking enough about long term determinants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

Concern had been expressed that HWBs might be more "talking shops" as they did not have statutory powers (HCLGC 2012, Humphries and Gelea 2013). However, respondents in our case studies were generally positive about their role and who was involved, despite some feelings that HWBs were still developing their roles.

3.5 Resources

The 2013 reforms established a new national protected public health budget, drawn from NHS allocations, and split between PHE and local authorities. Furthermore, the money allocated to local authorities was in the form of ring-fenced budgets (from 2013 to 2016), to 'protect' public health spend during the transition and early years. The ring-fencing of budgets was, and remains, contentious, with public health and government personnel generally supporting them, and local authorities generally resisting them (Riches et al, 2015). Whilst the intention was to prevent the public health grant being absorbed into other areas of the local authority at the expense of public health, there were in fact few conditions as to how the grant was spent (DH 2013). Consequently, there have been reports of and debates around the 'raiding' of public health budgets to fund services and activities that were not previously considered funded out of the public health 'pot' (Iacobucci 2014). At the same time though, there is a view that public health now has the opportunity to fund and invest in other departments that have an impact on the wider determinants of health. This came out strongly in our case study sites. Also, within our DPH survey, almost 90% of respondents (compared to 65% of elected members leading on health), suggested some of the public health budget has been invested in other local authority departments. However, in 19% of local authorities additional funds had been allocated to public health budgets. Although the budget has been used more broadly, the perception of DsPH is that key decisions about spend appear to remain mainly with them, with some involvement from other directorates (see figure 6). The view of elected members was that authorising this expenditure was undertaken more widely across the authority.

Figure 6: Who makes decisions about allocation of the ring-fenced budget?



Some DsPH and public health consultants in our case study sites felt they had more freedom and autonomy *before* moving to the local authority, although the amount of spend was seen to dictate public health freedom. Some sites outlined that there are budget restriction thresholds and lower sign-off limits following the move to the local authority which has impeded autonomy, especially as so many decisions go through cabinet (public health can sign off small amounts of spend with larger budget decisions going to cabinet). Some respondents referred to the importance of public health specialists' clinical roles as providing a degree of autonomy around decisions related to clinical issues as other local authority staff were not able to become involved in these types of decisions.

Our case study findings and the responses to the surveys also clearly show that in some areas *additional* funding has been provided to support public health activities. Findings so far suggest that, in some areas at least, public health professionals are beginning to influence resources and spending across the council as a whole, in addition to being largely in control of their own ring-fenced budget (see section 4.2 on influence across the council).

Across the local public health system as a whole, the splitting of NHS resources for public health during the transition phase was clearly difficult, posing particular problems in some areas. In one of our case study areas in particular, the initial allocation and distribution of funds has caused significant confusion and in some cases conflict and disagreement. Respondents in a number of sites mentioned problems encountered with funds being allocated to public health when it should have been allocated to CCG and vice versa. There is a continuing debate to clarify who pays for what and who has responsibility for what. Interviewees in all our case study sites referred to instances where relationships with other parties (e.g. CCGs, NHS England, PHE) were made difficult by the complexities and lack of clarity surrounding the splitting of funding pots.

3.6 Resource issues in two tier Council areas

In Site A, where there was a two tier structure, respondents mentioned the context of council budget cuts and how this has had an impact on the funding of the work that is going on in the district council areas. In one of our county sites some funding for public health activity was allocated to districts but there has been a pulling back to the centre as the county council strove for greater cost-effectiveness.

While there were many signs in our two-tier sites of positive co-operation and cordial relationships (see section 4.4 on public health and district councils), there were also signs of inherent tensions around the way that the public health budget is spent and allocated. When the county council is increasingly commissioning services on a county-wide basis, it becomes difficult to then break down the spending by district. One district council leader felt that this leads to confusion:

> *"they [the public health consultants] put forward an item agenda, we agree an agenda item, but we've got no idea of what resources that goes behind it and whether or not we'll be treated as fairly in our [local] HWB area as the others are. So basically there's no way of telling at present, well from where I sit anyway ... whether the needs of our community are greater than somewhere in [the west of the county] or so-on, so you get behind the public health data, but you don't get the commensurate funding understanding that sits behind it to deal with the issues"* (Leader, district council).

From a county-level perspective, this DPH talks about how widely the public health budget is spread:

> *"I do sometimes sit around the district table and people talk about what they're doing. I know I've sat around one before now and thought, you know, what, I fund all of that and I fund all of that. Oh, I fund half of that and I fund all of that. So, you know, I think it adds value to bring all the partners together at a local area, but having said that if you look at where the pooled resource comes from and the core sense of would this happen without the input from the county council and public health, the answer is possibly not. District colleagues would probably disagree with that but as long as it adds value I don't mind"*(Director of public health).

It should also be remembered that aside from council tax, councils can raise money from charges for services. So within counties, districts may have different revenue streams. This can lead to significant local variation – for instance, in one district popular with tourists, town centre parking provides a lucrative source of income. Other poorer districts do not have such sources of extra revenue and in turn have less funding to commission local services.

3.7 Organisational arrangements for public health – key points

We found a wide variety of sharing arrangements for public health, such as sharing services, sharing the expertise of public health team and joint DsPH between local authorities. These arrangements were both formal and informal. Following the transfer from PCTs, most of the public health teams had remained the same size or made smaller, however we saw some evidence of increased size among less traditional roles within the teams. Public health teams were located across a wide range of local authority directorates and there were some concerns that where the public health budget falls in social care, it may be lost or subsumed due to the directorate structure and the large size of the social care budget. While nationally our survey found that only just over a quarter of DsPH were in public health directorates most respondents in our case study sites stressed the importance of working across the local authority and externally and getting people to think about public health "in all they do".

Councillors interviewed in our case study sites believed public health was building good relations within local authorities and the public health role was valued by the council. This was echoed by DsPH in our national survey, with 79% saying they had 'definitely' built good relations with the local authority. A key role of public health teams is their work with elected members – a relationship emphasized by respondents in our case studies. The role of the public health professional is as an adviser to elected members and implementing decisions made. Our survey of DsPH showed that most felt 'quite often able' to influence priorities in their local authority and that the majority (82% - see also page 25 figure 8), felt more able to influence the work of the local authority as a whole than prior to 2013. The case study and survey data show public health staff stretched across a large number of roles, working 'corporately' and at a strategic level in councils.

In our survey most DsPH reported that the ring-fenced public health budget had been used to invest in other local authority departments, whereas only 65% of elected members thought this was the case. This was reflected in our case studies although this was not always discussed as a negative

point with references made to investing in other areas of public health activity across local authorities. More DsPH (58%) felt they were solely responsible for decisions on the allocation of the public health budget compared to elected members with this view (40%). In some authorities additional resources have been allocated to public health but there was limited evidence that public health teams are beginning to influence resource allocation across local authorities.

4. Relationships and functions within the local public health system

4.1 Roles and responsibilities in public health

In our case studies we asked interviewees about their roles and responsibilities in relation to public health within the new system (i.e. post-reforms). They talked about these roles in relation to other actors within the system, and with reference to their roles and responsibilities pre-reforms. Within the interviews, discussions about roles also emerged when talking about accountability, decision making and leadership. It was clear that the reforms brought about a great many changes in the roles of pre-existing actors (e.g. local authorities, elected members, public health professionals), as well as the creation of roles for newly formed actors (e.g. PHE, CCGs, HWBs, NHSE,CSUs). The fragmentation of the public health system – in terms of the fracturing of functions and division of responsibilities – meant that there was a considerable lack of role clarity.

In transitioning to local authorities, former-NHS public health staff had to learn about the structure, functioning and cultural norms of a new organisation. Sometimes, where a team was providing a shared service, this learning process was multiplied, with each different local authority having its own history, structure and ways of working. This was felt to be a considerable challenge, even where there had previously been a history of joint working:

> *"I think our big gap was that we... I think we did not understand what a big cultural change it would be. Because it's very different to come across here a few times a week or for a day a week and work here and then go back into the NHS which we all knew, to come here and have to take on all the organisational culture and structures and systems, and I think that kind of hit us a little bit"* (Public health consultant).

Public health staff in case study sites felt that local authority processes were complex and rigid compared to that of the NHS and had therefore encountered difficulties in adapting to them. Many interviewees outlined the challenges presented by the additional barriers and layers structured into the local authority decision-making process. As a result, there were frustrations from public health practitioners and CCG members across the sites that the decision making process was more protracted and slower than they had previously experienced in the NHS and as a consequence, the ability to make immediate decisions had been removed. One commissioning lead for public health in particular bemoaned the diffuseness of the local authority system and the need to go back and forth between different individuals at different levels to get decisions made.

A common theme is that there appears to be an informal check and review mechanism built into the decision making process, and a pre-emptive strategy of 'thinking ahead' in order to consider what leverage might be required to achieve the desired outcome. A DPH likened this to *"an evolutionary process"* and there was a sense from respondents of wishing to get "all their ducks in a row", with some respondents suggesting they check out ideas with significant actors before producing documentation or reports. This appeared to be being used as a pre-emptive measure of scrutiny to avoid failure of public health papers and to ensure that the process went smoothly. For example, in one case study site a public health board (which is cross directorate and inputs to the HWB) has been set-up:

> *"All the papers that go to the cabinet committee for public health also go through that channel first so they always look at the papers and give their views"*(Councillor).

This process of getting decisions made and ideas ratified with both officers and councillors was obviously made more challenging when working across multiple authorities. In one site, the public health team have developed a new stand-alone role to manage what they feel is a complicated and messy process.

The interview and survey data clearly show that public health staff are stretched across a large number of roles: working 'corporately' and at a strategic level in councils (and in 2-tier councils at district level too); linking with all other parts of the councils; leading the core offer to the CCGs; leading on joint strategic assessments and strategy development through the HWBs; managing teams of public health staff; designing and overseeing organisational structural change; reviewing and commissioning services, and so on. Some key themes emerged from discussions of their roles in the interview data.

4.2 Public health influence at a strategic level

Public health professionals, and the DPH in particular, have a role in influencing the council at corporate and strategic level. Several elected members said they wanted to see their public health team *"spread their tentacles across the whole organisation and indeed across CCGs"* (Councillor), and *"to go and enthuse the local authority into public health"* (Councillor). Interviewees also stressed, however, that public health staff have a key role as *"ideas people and visionary sort of people"* 'enthusing' others in the council for public health (Senior public health manager). They can also do this by raising the profile of public health issues, knowledge and approaches by providing information/data, by suggesting 'solutions', and by promoting a *"public health ethos"* (Senior public health manager). Interestingly, two DsPH stressed that the production of their annual report was a mechanism by which they could retain their professional independence and identity, hence suggesting the importance of the report in maintaining their status.

The DPH survey asked respondents about the ability of the public health team to influence decisions in their local authority. Most respondents (66%) felt 'quite often able' to influence priorities in their authority, with the rest fairly equally split between 'always able' (15%) and not often or never able (19%) to influence priorities.

It was recognised by some case study interviewees that the high-level strategic influencing role is not easy for incoming public health professionals to establish or manage. Having good support from other directors was seen to be important in fulfilling this corporate role. Several DsPH said that they would ideally be reporting directly to the Chief Executive. As one Deputy DPH explains:

> *"That would be the ideal scenario because you've got someone very high level saying, 'Oh well have you thought about the impact on the health and wellbeing of the population by doing that decision?".*

However, in one council this was seen not to be a panacea:

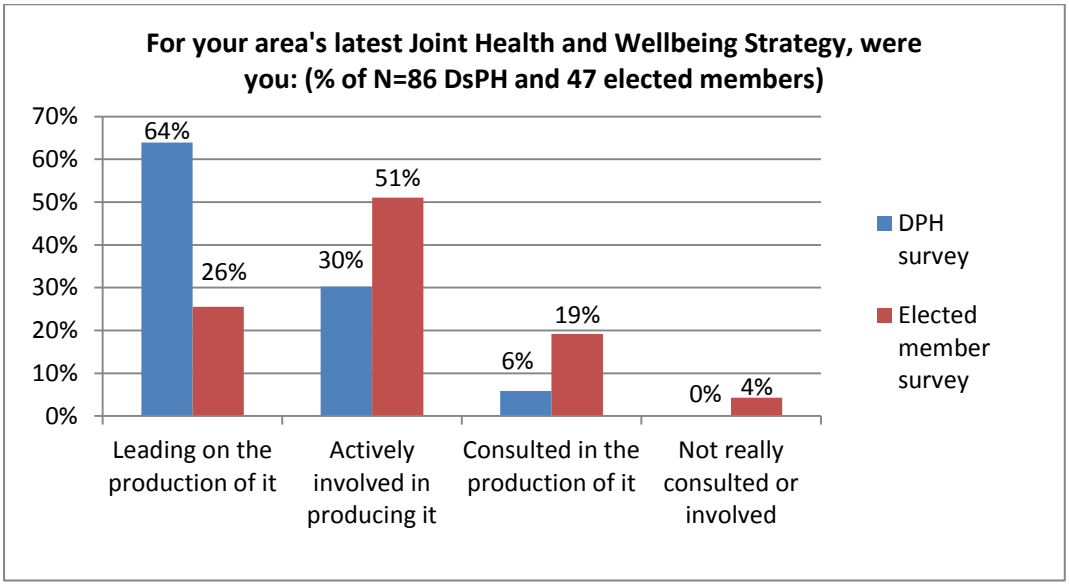
> *"…we're lucky that our Director of Public Health is responsible to the Chief Exec, but I think there's power based struggles going on there, with service directors that have got really high levels of responsibility and aren't used to that dynamic" (Joint commissioning manager).*

A DPH in one of our case study sites felt they had lost power – "*we're not really in a very powerful position"* - because their function has been pushed down the organisational hierarchy, and it was suggested that "*they are actually pushing us away from the board level we used to have"*. The DPH felt that public health had been placed at the wrong level in the organisation locally and was therefore not part of decision making at the strategic level.

Conversely, in one of our case study sites the DPH felt liked they had "*gained a bit of power"* because the local authority was receptive to public health ideas. He described the local authority as being interested in public health and therefore positive towards public health and their aims. He perceived the public health team to have an increased ability to influence decisions in the authority, but felt this power was constrained by budgets and resources. This view was mirrored in other sites.

Key areas for strategic influence are through the development of the Joint Health and Wellbeing Strategy (JHWS) and through membership of the HWB. Interviews with councillors and our survey results suggest that councillors are also involved in setting strategic directions for public health. While the DPH and their team were much more likely to lead the production of the JHWS, cabinet leads were often actively involved (see figure 7).

Figure 7: DPH and councillor involvement in producing the Joint Health and Wellbeing Strategy

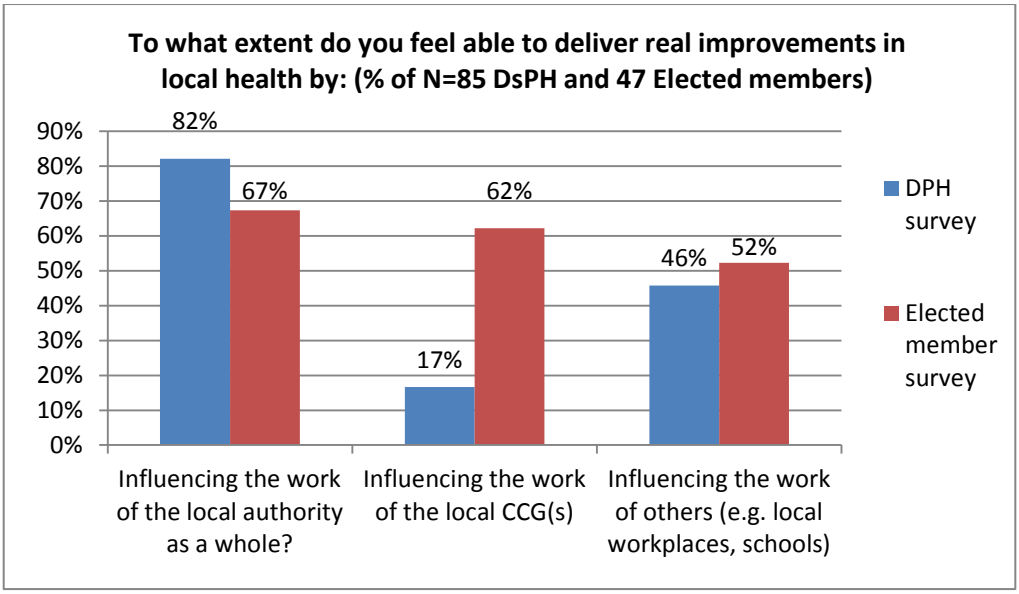


When the DPH was not actually the lead person, leadership came from a variety of other parts of the authority, such as corporate/strategic/planning/policy teams.

Despite some tensions identified in the case study work, the DPH survey indicated that the overwhelming majority (82%) of respondents felt more able to influence the work of the local authority as a whole than they could prior to the reforms. As well as feeling more able to influence

the work of the local authority just over half (54%) said they also felt more able to deliver real improvements by re-prioritising what they do as a team. There were indications that this enhanced ability to influence others extended beyond the local authority setting too: the survey found just under half (46%) felt more able to influence the work of others such as schools. Interestingly, while public health professionals felt they had gained influence within the authority, elected members reported that they had gained influence with CCGs, but with both feeling more able to deliver health improvements in schools and workplaces (see figure 8).

Figure 8: Influencing improvements in local health



DsPH who 'always' felt able to influence priorities within their authority were also more likely to say that since the reforms they were more able to influence the work of the local authority, that they had influence over other departments' expenditure, and that being on the HWB allowed them to influence decision-making in their own organisation. There was also an association between influence in the authority and feeling able to deliver real health improvements in other areas like workplaces and schools.

Both the case study data and survey data highlights a relationship between organisational arrangements and the degree of influence afforded to or felt by public health professionals. In the survey, it was found that where the DsPH were not managed by the council's chief executive or a director of health, they were more likely to report that they were not often or never able to influence priorities within the local authority (23% compared to the average of 15%).

In addition, analysis of the survey data suggests that characteristics of the authority where DsPH were based such as the type of authority, the political party in power, the number of residents and the size of the public health budget, also had an effect on DPH views on their degree of influence, thus pointing to the importance of local context. The survey results illustrate that there were local factors in connection with feeling able to influence priorities within the local authority, and whether being on the HWB allowed DsPH to have influence more widely in the local economy. DsPH who said they were always able to influence the priorities in their authority were less likely to be in areas with greatest material deprivation (4% compared to the average of 15%), and more said they were

always able to influence the priorities in their authority if they had high per capita public health budgets (29% compared to the average of 15%).

Overall, the survey indicated that public health is beginning to influence resource use across the local authority – not just the ring-fenced public health budget. A small proportion (10%) of respondents to the DPH survey felt they had quite a lot of influence over other departments' expenditure; over half said they had limited influence (54% said 'yes, but not a lot'). Some authorities had provided additional funds to the public health ring fenced budget (19%) – generally areas of council expenditure previously classed as public health but also included, for example, community safety, HealthWatch and advocacy and emergency planning where it was seen as part of the DPH role.

4.3 Cross-system influence and co-ordination

Another key role for public health professionals is around cross-system influence, intelligence and co-ordination. Public health:

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

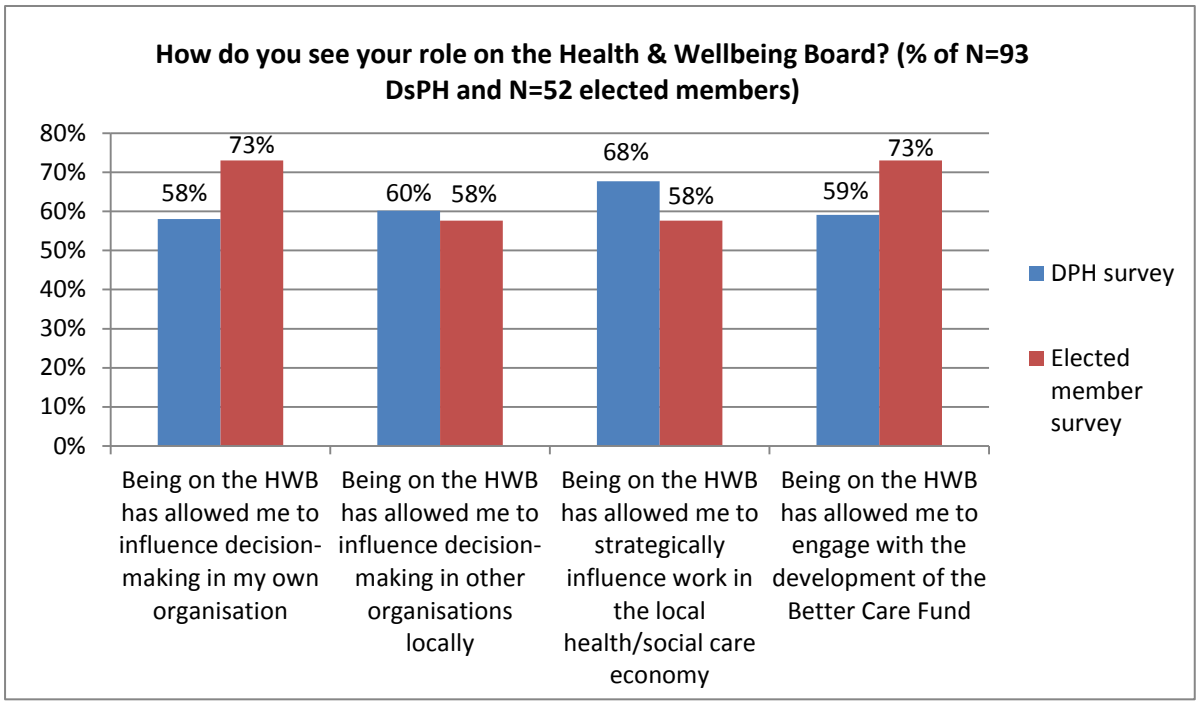
Having moved into the local authority, it was stressed by many respondents that public health staff should not forget to work with CCGs e.g. through the provision of a core public health advice/data service and linking into the agendas of other local organisations. In our case studies public health consultants demonstrated that their roles now focused on making connections – across the council, and externally, linking in to other agendas (e.g. sustainability), and identifying 'co-benefits'. In one site, public health team members have scoped specific issues (e.g. dementia), to enable a focus on them within HWB meetings. In another, public health team members seek to influence commissioning decisions in their CCGs and across the council, partly through providing public health intelligence, but also acting as leading and supporting "… *the system to deliver public health" (Director of public health).* Our survey data suggests that this shift has been significant with the move to local authorities making a big difference to the extent to which DsPH feel able to have an impact (as seen in figure 8).

In influencing the system, participants often talked about using specific relationships as levers; key relationships would be used to help to smooth the process, understand what is required to get papers through the local authority and also to get political priorities agreed. The influence of existing relationships and connections was referred to, as was the influence of knowing 'personalities' which could be tapped into. For example, one senior public health manager stressed the importance of having continuity of people/legacy relationships (in the NHS) suggesting that it is beneficial to work with people that they have worked with in the past, even though they may be in different organisations. This continuity of relationships has been difficult in a system that has been thrown into such flux, with many people moving into different roles, organisations and geographical areas. Building new relationships with councillors, politicians, health leads and the council leader

was also mentioned as being important in terms of influencing and getting decisions made, particularly in terms of providing support for DsPH in getting major decisions through.

It is clear both from policy documents and from our research data, that HWBs have an important role to play in cross-system coordination. When interviewees talked about HWBs, it was usually with a sense of optimism. HWBs were seen to play a key part in (potentially) pushing ahead system change, particularly around the integration agenda. Their position in the council, and their membership - often chaired by the leader of the council, was seen to give the HWB the opportunity to progress on the whole redesign of the system, taking the public with them as they do. For DsPH the main benefit of the HWB was that it was 'definitely' instrumental in identifying main health & wellbeing priorities (61%) although as many as 63% of DsPH felt that the HWB was 'not really' making difficult decisions. One senior manager described it as *"the place to come to"*, given its high profile and membership, however, in our survey only 55-66% of DsPH felt that membership of the HWB was enabling. As figure 9 shows, the responses for elected members were fairly similar, but slightly more positive, with more saying that membership of the HWB allowed them to influence decision-making in the authority (73%) and to engage with the development of the Better Care Fund (73%).

Figure 9: Role on Health and Wellbeing Board



While DsPH and elected members were very similar in the way they ranked the benefits of being on the HWB, cabinet leads were hugely more positive about the powers of the HWB on every aspect we asked about (See table 2). For example, elected members rated identifying the main health and wellbeing priorities most highly (86% said 'definitely' compared to 61% of DsPH), followed by strengthening relationships between commissioning organisations (77% said 'definitely' compared to 40% of DsPH). At the other end of the rankings, 35% of Cabinet leads compared to only 6% of DsPH felt that the HWB was 'definitely' making difficult decisions (see table 2).

Table 2: In your opinion is the Health and Wellbeing Board… (% of replies in DPH and elected member surveys)		Definitely	To some extent	Not really	N
Instrumental in identifying the main health and wellbeing priorities?	DPH	60.5	33.3	6.2	81
	Cabinet Member	86.0	14.0	0.0	43
Strengthening relationships between commissioning organisations?	DPH	39.5	51.9	8.6	81
	Cabinet Member	77.3	18.2	4.5	44
Beginning to address the wider determinants of health?	DPH	23.5	49.4	27.2	81
	Cabinet Member	59.1	36.4	4.5	44
Influencing cross-sector decisions and services to have positive impacts on health and wellbeing	DPH	14.8	64.2	21.0	81
	Cabinet Member	50.0	43.2	6.8	44
Facilitating the greater use of collective budgets?	DPH	12.3	55.6	32.1	81
	Cabinet Member	43.2	50.0	6.8	44
Helping to foster a collective responsibility for the use of budgets?	DPH	9.9	63.0	27.2	81
	Cabinet Member	40.9	45.5	13.6	44
Successfully incorporating active citizen involvement?	DPH	9.9	42.0	48.1	81
	Cabinet Member	15.9	68.2	15.9	44
Making difficult decisions?	DPH	6.2	30.9	63.0	81
	Cabinet Member	34.9	51.2	14.0	43
Directly commissioning services?	DPH	1.2	11.1	87.7	81
	Cabinet Member	16.3	37.2	46.5	43

Interviewees in our case study sites highlighted the HWB role in forging new or better relationships between different actors within the system – in particular between elected members and clinicians, which in turn offers opportunities for change and improvement:

> *"… we insisted … that the one relationship we had to get right was between elected members and clinicians, because they were the only two new entrants into the health and wellbeing board as far as we were concerned, everybody else had been there before"* (Senior strategy manager).

In addition, HWBs have a role in encouraging new ways of working for health improvement, perhaps by focusing on a particular health issue and tasking others across the system with looking at how they might be able to assist in dealing with it, or by 'shaking things up' and putting pressure on system actors, or by system actors putting pressure on each other, asking what more they can do, or what they can do differently. This role of applying pressure has a performance management/ scrutiny aspect to it, which one senior manager described as *"hold[ing] public health activity to account".*

The operation of HWBs in our case study sites clearly reflected their relatively embryonic state – these complicated bodies were taking time to take shape. Perceived concerns included a lack of statutory powers and the ability to balance different agendas. The work load – and possibly type of work – of the HWB was sometimes different to anticipated, and boards were sometimes meeting with increasing frequency, and creating numerous 'sub-committees' and working groups, to cope with the work. Another evolving aspect of HWBs is their roles in relation to decision making, where

> *"…technically they [HWBs] have no decision making powers because the… the governance of the board goes back to the organisations in which the members are part, so the board itself has no formal decision-making powers"* (Public health manager).

4.4 Public health and district councils in two-tier authorities

A key issue within county areas has been the relationship between county and district councils. The government recognised within their public health white paper that district councils have important public health functions (DH 2010). Relationships between county councils and district councils are complex and not always easy. In one of our county sites, a district councillor commented that relationships across this county were surprisingly good:

> *"[The county] is odd. … But we are a two tier system, yet the districts and county, generally speaking, actually work well together. Now that's, I understand, odd … the county has the ability to work in partnership with the districts, which is unusual"* (District councillor).

This may be partly due to the district council network in the county, which coordinated work, communication and co-operation between the districts. But it was also due to good working relationships between individuals:

> *"…you might have difficult conversations, and we certainly have had some interesting conversations about where districts are involved in informing the commissioning work of public health at a county level on some things, and come to a place where it works, or it will work".* (hief executive, district council).

Conversely in our other county site the relationships were not always good. Nevertheless, relationships on the ground, particularly between public health staff and district councils, were felt to be better than those at member/leader/chief executive level. In both counties, public health professionals recognised that – whilst being situated at county-level – they need to work with district councils, a point also recognised by respondents at district levels;

> *"… you know, you can't deliver public health without actually influencing housing, planning, environmental health, leisure…[all district council responsibilities]"* (Chief executive, district council).

Engagement in public health activities varied from district to district, and the split of functions and responsibilities across district and county councils presented both opportunities and challenges. There are a number of reasons expressed by interviewees about why county-level public health staff

are working hard to engage with district councils. Of particular importance was that districts provide a wider workforce to tap into and, if the public health professionals can link better with the public health-oriented work that is already going on within district councils, they can maximise opportunities and improve results. District councils have a lot of assets which make them, in some cases, ideal providers of services. In one of our county sites, as a result of historical differences between two halves of the county (where two former-PCTs did things quite differently), districts in one half continued to receive public health funding to carry out health promotion activities (e.g. in smoking cessation and healthy weight services), whilst in the other half of the county, that funding was used to commission a community health services provider. In our other two-tier site, much of the commissioning related to obesity is delivered at the district level and is described as being "district focused":

> "*So that's the way I see us fitting in really, it's that bringing it all together, raising the standards, you know, commissioning it in a more efficient and cost effective way and delivering that through district partners*" (County council manager).

This desire to work together came both from public health teams and from district councils. District council respondents saw the potential to be more involved in health improvement for their population, and at the same time recognised that their own role, in relation to health, had changed over time. They felt their role was no longer about allocating housing and hoping that complex needs would be met:

> *"…there was that gap. So it's fine for us to do all the housing and environmental health, but actually, if someone's not getting the maybe emotional and mental health and wellbeing that they require, we're not actually improving their quality of life to any great degree"* (District council officer).

District councils were also seen as being closer to people and better placed to tackle things that are 'very local' – particularly where, in a big county, the county council is often described as being too big and too remote:

> "*…we're best placed probably to know what's going on in our patch than maybe somebody sitting in an office at county hall who's trying to see everything "* (District council senior manager).

> *…the thing is that their [district councils'] concern is more to do with their local population so they're keen to put into place things that mean that their local population's health improves"* (Public health consultant).

We found an example in one case study site where a CCG had provided some money for a district council to fund voluntary groups undertaking small projects linked to health and wellbeing (e.g. a befriending project) that were carefully targeted and had a high level of engagement from local people. It was argued that locality is important because it is built on the relationships that the district council had with individual GPs that predated the formation of the CCG. These relationships helped secure the funding. One county councillor (and chair of the HWB) commented that districts

"*bring a lot to the party*" when discussing public health. The knowledge of what is important at the local level comes through the work of local boards and this can be balanced with the broader county aims. This councilor felt that public health issues such as obesity are discussed more frequently and more meaningfully at the local level.

District councils also provided an alternative decision-making route for bringing about change where, for example, a topic or policy area does not gain traction within the county council cabinet (e.g. for ideological, political or personal interest reasons):

> *"So if you've got a policy area, for example... if you've got an area of policy that you know that [the county council] find a challenge... You go and work more with the districts"* (Public health consultant).

Respondents also highlighted the need for greater co-ordination given the fragmentation of the public health system, with greater potential for variation in activity, and potentially a waste of resources, if not managed carefully. For instance, in site D, it was felt important that district council work on health and housing was interweaved with what is going on at county level.

4.5 Working with elected members

A key role of public health teams is their direct work with and for elected members. These relationships are crucial, and point to a major role change for public health professionals since the reforms. Within the NHS, a senior public health professional may have been independently making decisions which were subsequently ratified by a chief executive or finance manager. Within a local authority, though, a senior public health professional is chiefly an *advisor* to the decision makers – the elected members. Their role was described as assisting elected members to make decisions, by providing them with information, advice and suggestions. In addition to helping elected members to make the decisions, they are also responsible for operationalising those decisions/policies/strategies once made.

Elected members, in turn, have also experienced a change in role, and now have an important potential to champion public health issues. They also have an important role in holding the local public health system to account - directly through their scrutiny of the council's public health officers, and more broadly through health scrutiny committees and the HWB.

Importantly, their position within the local public health system was seen in policy as best placed to deal with local issues and afford greater democratic accountability (DH 2010). Interviewees in the case studies were generally positive about having greater democratic accountability, suggesting this has led to a more corporate approach looking across the system/council/communities.

> *"There's a great rigour then working within the council, because of that democratic accountability, which obviously in terms of the Health and Social Care Act, was one of the elements that we'd have to hope, that the coalition government were trying to introduce into the NHS"* (Councillor).

> *"… because the councillors tend to be closer to the electorate, they can give a clearer view in terms of this is an issue or this is very important, this is something that, you know, the community would feel very strongly about. Whereas a public health professional is coming at it from a different angle"* (Councillor).

While public health staff and councillors talked about the public and public accountability it was in different ways. Councillors view the public from a particular perspective that is informed by experience and contact – often at a very local, ward level. Public health staff did see this as positive but also referred to it as a problem in relation to what *they* saw as priorities, based on more formal needs assessment and evidence. For example one DPH referred to a local situation regarding alcohol:

> *"… I remember the conversation we had with members and we were talking about alcohol and we said to them, "Well actually the best thing you can do is stipulate minimum pricing," because that would change the environment hugely. Really good evidence for it. Price controls supply and therefore demand. "Well over our dead body!" They took it like that. It was sort of like that. So I think the big challenges are where we're advocating something at a population level that is just not palatable from a political..."*

Elected members were felt to bring different types of knowledge - more granular knowledge, arising from their knowledge of their constituents - which could play a part in making those services more relevant to their communities, and different ways of seeing things, which could provide a bit of a 'sense-checker'. One public health consultant explained elected members can provide a *"likely public acceptability check"* for experts. In describing the way she works with her public health professionals, an elected member explained:

> *"So it's... so there's a sort of... there's a different nuance, if you like. You know, [senior members of the public health team] clearly are the experts and the professionals, but my role is more to look at how we can... how we can make those services more relevant"* (Councillor).

Elected members were felt to have a leadership role, in the sense that they could provide public leadership that can help 'bring people with them' through the inevitable changes to the health and social care system, but also by liaising with and influencing others, potentially driving change and helping to 'champion' public health amongst wider stakeholders. One public health consultant explained that if you have a positive relationship with councillors, there is greater potential for change:

> *"If they can locally support the planning side of things, if we raise their awareness around what is the role of planning in managing obesity and the role of licensing in management of obesity - I'm sure they know of it, but it's about articulating that in a public health manner for them, and getting their support - then I think, you know, they are the influencers and drivers at a local level where things have potential of changing"* (Public health consultant).

Councillors were seen to bring greater potential to influence others by enabling a wider 'reach', outside the council (through their external connections), across the council (through committees, etc.), and down to a more local ward level and their constituents. Two case study DsPH described their elected members as *"real advocates"* for public health. Meanwhile, one elected member saw himself as an advocate for others – he talked about being there *"to support vulnerable people".*

Elected members were also clearly identified in the sites as the decision makers within councils, and have power in ratifying papers before going to the cabinet. Officers recognised that the cabinet member had to agree and approve papers before anything else happened and therefore there was a need to get them 'onside':

> *"…so I suppose ultimately, decisions are influenced by the cabinet member. That's who you have to get on side to get anything to happen, really, in effect"* (Deputy director of public health)

It was also clear that the personal views, ideologies and interests of elected members (particularly cabinet members) played a part in determining what got prioritised (e.g. physical activity, smoking), and the types of public health decisions made. This could be a source of possible tension for public health if their remit and the cabinet members' interests do not align. Alongside this, councillors also suggested that national policy and the political agenda influenced what they decided to respond to and prioritise. One elected member saw his role as being to implement government legislation, e.g. in regards to health and social care integration. It was recognised that they hold multiple responsibilities which sometimes conflict. For instance, their public health role might clash with their role to promote business (e.g. in terms of introducing legislation to limit fast food outlets), or to maximise income (e.g. in terms of investing pensions into tobacco companies).
Whilst public health professional interviewees recognised that elected members can sometimes be a distraction (for instance, by coming up with lots of questions that they want answering), they were also very positive about their relationships with them, and seemed to see the value they (potentially) add.

4.6 Statutory commissioning responsibilities

Another key role relates to the statutory responsibilities with regards to commissioning services, as well as delivering the core advice service to CCGs. Public health professionals (and others) talked about their roles in commissioning new programmes, managing contracts, and managing the performance of providers. We found some evidence of there being a greater onus on the DPH to performance-manage those contracts better than before, and sometimes a blurring of whose role it is to step in when there is poor performance:

> *"we have a performance report and a RAG [red, amber, green traffic light system] rated report that flash sort of red for health checks and, yeah, the cabinet member doesn't like things flashing red on his performance report and he hadn't thought through how to... well whether he as opposed to the commissioning managers in the public health team ... you know, how he should tackle that with the trust"* (Strategic director).

There are also suggestions that this role is complicated, and is not always understood by others:

> *"…it has thrown up some interesting issues. Councillors talk about delivery all the time without always kind of understanding the sort of nuance about the difference between delivery and something like this which is largely a commissioned activity or delivery of, you know, fixing the potholes in the road – something much more tangible albeit actually, you know, contracted out a*

lot. So, yes, they'll talk about public health have to deliver as if, you know, the public health consultants themselves are out there, you know, weighing kids and delivering the services they commission" (Director of public health).

In one interview, a long-time local authority commissioner who had become part of the public health team following the reforms explained that there were cultural differences to how commissioning is approached in local authorities and the NHS:

"We [local authority employees] were faced with a lot of ignorance about commissioning and a lot of ignorance about local authority style commissioning and business processes amongst our [public health] colleagues and we were sort of faced... I was shocked actually by the lack of understanding of what we had been doing or what we did" (Public health commissioner).

Indeed, this interviewee questioned the role of public health professionals in commissioning:

"I don't think they are commissioners ... I don't think they understand it. I don't think they understand commissioning so I don't understand why you have to be a public health person – a qualified public health person – to actually commission public health services" (Public health commissioner).

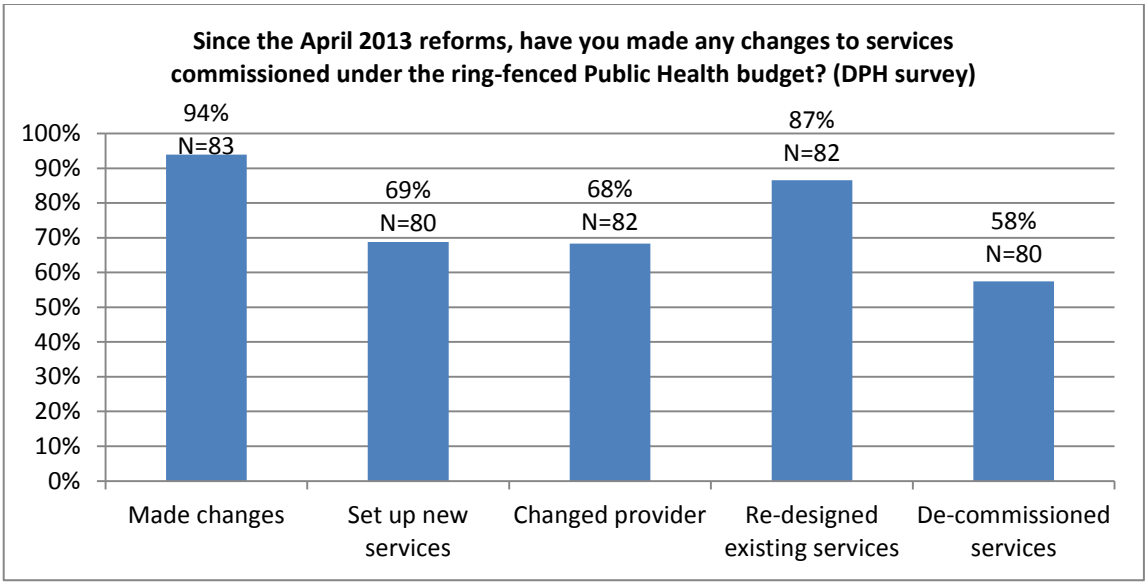
In at least one of our case study sites, new commissioning staff were recruited into the public health team to strengthen their capacity in this area. Respondents in our case studies often referred to capacity problems and the need for support:

''*...just got by really and done stuff internally ourselves and I think now we're trying to…there's been some, sort of, departmental reorganisations to put in place some contract managers, and stuff, within the team, so we're building up some of that background support, which will take the weight off us a little bit as front line, sort of, commissioning managers"*(Public health consultant)

There is a sense from our case studies that there is a more rapid/frequent commissioning cycle in local authorities – contracts tend to be shorter than those traditionally commissioned in the NHS – with more frequent and critical reviews. Almost all DsPH (94%) responding to the survey reported having made changes to services commissioned under the ring-fenced budget since the reforms (Figure 10) with almost all (94%) having started the process of re-tendering health improvement services and most had re-designed existing services with changes in providers.

Changes to commissioning were more common in authorities where the DsPH felt they were 'always' or 'quite often' able to influence the priorities of their authority - 92% of those who always felt able, and 98% of those that quite often felt able to influence priorities had made changes, compared to 81% making changes in authorities where DsPH said they not often or never had influence. The directors with influence were twice as likely to have set up new services (77% compared to 38%) or have changed the provider of an existing service (76% compared to 38%).

Figure 10: Changes made to commissioning services under the ring-fenced public health budget



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4.7 Relationships with PHE

Relationships with other organisations were not specifically explored in this phase of the research. However, our survey data suggested that there were positive relationships between DsPH and their local PHE centre with 72% of DsPH saying they had received a good or excellent level of support. However, substantially fewer DsPH reported that they had good or excellent support from the PHE regional team (23%), and only 13% felt well supported by the PHE national team. There was some criticism of the system rather than the staff as reflected in the following open comments from the DsPH survey:

> *'This is not a criticism of the good colleagues who work there but more one of the system design whereby guidance is produced nationally by PHE and NICE and action taken locally by LAs.'*

> *'Personally I think PHE involvement in health improvement weakens the ability of LA PH teams to be seen as local leaders.'*

Conversely, elected members rated the support from PHE overall quite highly in the survey, with 54% getting good or excellent support overall from PHE. They were not particular familiar with the local PHE centre and the following is a typical comment by an elected member:

> *'Making a positive contribution, but low awareness of them in general'*

4.8 Relationships and functions within the local public health system – key points

Our findings suggest that there have been changes in the way that DsPH and the public health team work within the local public health system. These changes have brought complexities and new challenges, such as working more closely with district councils and maintaining engagement with CCGs. The role of district councils appears to be important and in our two county council sites both district and county councils saw their collaboration as a key part of delivering public health in local communities. How the relationship develops, however, is dependent on a wide range of factors with day to day working developing even where more strategic engagement is lacking. While the vertical link with districts is seen as important, the vertical links to PHE are viewed less favourably beyond local links with PHE centres.

One policy intention was that DsPH would be advisors and leaders in the public health system. Our data provides good evidence that public health teams and elected councillors are working together and that, generally, councillors have welcomed the involvement in public health. However, this can lead to tensions where priorities between councillors and public health professionals differ. Councillors bring local knowledge and expertise to public health. We did not find evidence of this tension creating substantial problems in our case study sites, but respondents recognised that this was a factor to be constantly borne in mind.

While HWBs are seen as having an important strategic role, there were mixed views about their effectiveness. Councillors were more positive about their role than DsPH, and concerns were expressed that public health was not a strategic priority given the wider role of the Board. Generally the feeling was that their role is still developing.

One significant change has been in the commissioning role of public health. Commissioning in local authorities is substantially different to the process that existed in PCTs. This has been both a challenge to adjust to new systems and accountabilities, but also an opportunity to make changes to services.

5. Discussion and conclusion

In this first phase of data collection, including both case studies and the national survey, we have found that despite the complexities of embedding public health within local authorities, and continuing changes and pressures arising from both the development of the public health function and resource challenges faced by local authorities, there was a sense of optimism surrounding the public health role of local authorities.

While we focused attention on the models of organisation for public health within local authorities, our findings suggest that the inter-organisational arrangements and relationships between local authorities are important. Local context is also important on so many different levels: structural context; financial context; 'attitude' (to public health and the transition); 'political' context. The increased linkage between public health staff and local councillors is generally seen as positive by both public health staff and councillors.

This is an on-going issue, and reflects findings from other studies (Association of Directors of Public Health 2014, Mansfield 2013, Royal Society for Public Health 2014, Willmott et al 2015). There appears to be ongoing organisational change within local authorities as they respond to constrained economic circumstances within local authorities which continue to face resource reductions. Our findings reflect earlier studies that show that while organisational reforms have created wider opportunities for public health to have an influence, these come with challenges such as increasing pressure on decisions and potential loss of control over how and where the public health ring-fenced budget is spent (Iacobucci 2014, Willmott 2015).

Our findings, like other research, highlight the fragmentation of the new system, and the continued state of change as structures and processes find their feet, and as roles and relationships are developed (see for example Mansfield 2013, Willmott et al 2015). This is occurring in the context of wider change, as local authorities (and others) continue to adapt to deal with financial pressures. In addition to fragmentation, our case study findings pointed to a sub-optimal system design (with sometimes negative feedback and unintended consequences), and current prematurity of organisations. There were some tensions related to the resulting lack of role clarity which have, in some cases, influenced relationship building amongst system actors. Governance of such an emerging, fragmented system is a huge challenge. The data considered for this report related mainly to local level governance. Our research team also collected data on relationships 'upwards' with PHE and NHS England, which will be considered in our next report.

At the local level, there appears to be stronger managerial accountability and scrutiny, led by elected members (influenced by their politics, ideology and granular knowledge). This is shining a new light on public health activity, and is bringing an important window of opportunity for change – we saw evidence of historical commissioning decisions being challenged, new questions being posed, new suggestions being made, and 'permissions' being granted to *think differently*. This might be simultaneously liberating and challenging for public health professionals. In addition, whilst scrutiny from elected members was accepted and even welcomed, managerial accountability to directors of

other services appeared less easy to accept – perhaps because of the high status afforded to DsPH within local NHS organisations.

Our case study findings highlight the enormous impact that the change in organisational culture has had. This was not necessarily a negative view but that councils work differently with more accountability and a need to work with others. Feelings about this varied amongst interviewees within the same local authority. One person can find the new bureaucracy more accountable and transparent leading to more evidence-based commissioning of services and a clearer sense of tracking commissioning outcomes, while others find the system overly bureaucratic, slow, set in a certain groove and unable to accommodate innovative commissioning.

The role of the DPH in terms of system leadership has changed and become more dispersed. Instead, the new system gives rise to the potentially huge role a leader/chief executive can play in terms of determining the importance and focus of public health goals and activities. The power and potential influence of the DPH might depend very much on his/her relationship with key elected members, and will be channelled through a host of decisions regarding structural and managerial arrangements. Issues related to internal organisation and structure – including the position of the public health team within the organisational structure, the line-management of the DPH, and the inter-departmental fora on which the DPH has a voice – seem to be important in determining power, influence and relationships. Rather than being a given, the DPH's leadership role might emerge, given the right ingredients and nurturing. Willmott et al (2015:4) in their study of DsPH in the south west also found changes to the way DsPH are working "… *DsPH are responding with political sophistication; negotiating autonomy and influence; navigating pre-conceptions about public health; framing their expertise to foster legitimacy while building relationships."*.

In such a fragmented system, the HWB is crucial in ensuring local governance and stewardship. However, whilst the HWB was seen as having a role in 'holding public health activity to account', it did not have any inherent power to fulfil this role, and it was unclear how this might work. Data suggested that HWBs have dual roles of building better relationships whilst at the same time applying pressure and scrutiny. These roles may be uneasy bedfellows. Also, it was seen that the remit of the HWB is extremely broad, and certainly in the period of time in which we were collecting data, the dominant priorities were integrated care and the Better Care Fund (LGA 2014). That councillors were more optimistic about the HWB role than DsPH may reflect the different institutional positions they hold, with DsPH primarily looking to HWBs for a stronger role in public health, while councillors are more engaged in their broader overall health system role. Our data suggest that HWBs have not developed an executive decision making role but remain information exchangers and focused on a co-ordination role – supporting the findings of other research (Humphries and Galea 2013).

One aspect of sub-optimal system design can be seen in two-tier council areas. Insufficient attention was paid to the important public health functions in district councils beyond those resulting from the 1984 Act (Secretary of State 1984) – including for example, leisure, housing, licensing, and planning (District Councils Network 2014). It was clear from our data that working out this relationship (between district councils and county-based public health teams) is crucial and appears to be

developing differently in different areas. In some areas, we have seen district councils seizing the initiative and taking a key and active part in public health leadership. Elected members here, like their counterparts in the upper-tier authority, are challenging public health professionals, and seeking to influence them, as well as wanting to draw on their professional skills. Public health professionals, in their turn, are recognising the potential advantages to be had in engaging with this tier – despite the investment costs. In our two county sites, we saw how district-level HWBs were, in some cases, much more of a focus for public health discussion and action than the upper-tier boards.

Prior to the reforms, the corporate identity of public health professionals was shaped by being part of the NHS. In the new system, public health staff have to develop a corporate identity as part of a particular local council. Organisationally, these are very different to local NHS organisations – they are democratically run, autonomous, locally-focused organisations. With this identity comes a new form of corporate accountability and political awareness, which some public health professionals have found doesn't sit comfortably with their professional autonomy and 'independent voice'. At the same time as developing this corporate identity within the local council, public health professionals are supposed to not only challenge the council and hold *it* to account for its progress (or otherwise) on health improvement and health inequalities, but they are also expected to work closely with a range of other organisations across the system.

The changes in roles across the system do seem to lean towards consequent changes in approaches to public health and activities for health improvement. We have seen windows of opportunity opening. However, it is not yet clear how long those windows will be open for – particularly given the current requirement to cut budgets – and it is not yet clear what public health teams, working with others across the system, will make of those opportunities. It is also possible that the new duties and responsibilities for public health will shape councils in different ways – for example, if directorates/departments and ways of working become ever more cross cutting and integrated (rather than based on specific individual services), elected members will also have to start rethinking their portfolios and ways in which they have traditionally worked. In addition, elected members will have to reconcile their roles in improving health with their roles in promoting economic development, or even in supporting other local political priorities.

In our next round of fieldwork, we will shift the focus towards exploring some of the emerging themes in the context of obesity where we are examining three aspects of work:

1. Relationships between local authority public health and the delivery of clinical obesity services (i.e. links with CCGs and NHSE).
2. Obesity prevention work in schools with a focus primarily on inter- and intra-local government relationships and relationships between public health departments and schools and community health services (e.g. school nurses).
3. Examining the relationships between public health departments and planning functions in local government focusing on intra-organisational county/unitary issues and county/district relationships.

In addition we are conducting a limited number of interviews at the regional and national level to examine key relationships between local authorities and PHE (national/regional) and NHSE (area teams, specialised commissioning). The findings from this fieldwork will be incorporated into our third and final report at the beginning of 2016.

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