

Commissioning public health services: the impact of the  
health reforms on access, health inequalities and innovation  
in service provision

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## Abbreviations

ABCD:	Asset-Based Community Development
BMER:	Black, Minority Ethnic and Refugee
BOS:	Bristol Online Survey
CAMHS:	Child and Adolescent Mental Health Services
CCG:	Clinical Commissioning Group
CE:	Chief Executive
CSU:	Commissioning Support Unit
DCLG:	Department for Communities and Local Government
DH:	Department of Health
DsPH:	Directors of Public Health
FNP:	Family Nurse Partnership
HIA:	Health Impact Assessment
HEA:	Health Equity Assessment
HWB:	Health and Wellbeing Board
JHWS:	Joint Health and Wellbeing Strategy
JSNA:	Joint Strategic Needs Assessment
LGA:	Local Government Association
MECC:	Making Every Contact Count
NCB:	National Children's Bureau
NCMP:	National Child Measurement Programme
NHS 5YFV:	NHS Five Year Forward View
NHSE:	NHS England
NIHR:	National Institute for Health Research
ONS:	Office for National Statistics
PCT:	Primary Care Trust
PHE:	Public Health England
PHOF:	Public Health Outcomes Framework
PRP:	Policy Research Programme
SROI:	Social Return on Investment
STP:	Sustainability and Transformation Plan
VCSE:	Voluntary, Community and Social Enterprise
VONNE:	Voluntary Organisations' Network North East

## 1. Study aims

*Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision* is a research project funded by the NIHR Policy Research Programme (PRP). Carried out by a multi-institutional and multi-disciplinary research team (Universities of Durham, York and Coventry and Voluntary Organisations' Network North East (VONNE)), the project began in January 2015 and ended in June 2017. An External Advisory Group (EAG) provided regular support and advice (see Appendix 8).

The aim of the study is to evaluate the impact of the public health reforms set in motion by the Health and Social Care Act 2012 and the extent to which policy intentions underlying the reforms have been realised. The reforms gave local authorities new responsibilities for improving the health of their populations, new budgetary and commissioning responsibilities through the transfer from the NHS of a ring-fenced public health grant and new staff, through the transfer from the NHS of Directors of Public Health (DsPH) and their teams.

Research objectives of the study were as follows:

1. To investigate trends in the deployment of the ring-fenced public health budget, document changes in the balance of commissioned public health interventions and compare changes to trends in relevant outcomes;
2. To explore the impact on uptake and, where feasible, on selected outcomes, of changes in commissioning for selected preventive services;
3. To assess the extent of integration of selected preventive services across Clinical Commissioning Groups (CCGs), local authorities and other agencies;
4. To identify innovation in the choice of providers commissioned to deliver public health services and in the approaches they adopt;
5. To assess 'added value' from budgetary initiatives, including pooling arrangements across public health and other local authority budgets;
6. To identify changes across local authority directorates as a result of new public health responsibilities;
7. To assess the extent to which the Public Health Outcomes Framework (PHOF) influences public health priorities;
8. To identify methods adopted for involving different age groups in public health commissioning;
9. To identify enablers and barriers to public health commissioning, including commissioners' views on how the system can be improved.

Objectives focused on three workstreams reflecting new public health responsibilities arising from the reforms. Innovation, community engagement and addressing health inequalities were overarching themes for the study and reflected across all three workstreams.

The first workstream investigates how local authorities deployed their public health budgets. Budgets were estimated from previous NHS preventative spend, ring-fenced (unlike in the NHS) and subject to regular reporting to the Department for Communities and Local Government (DCLG), initially against 18 budget categories. Six of these categories were mandated services, with a substantial 'Miscellaneous' category as one of the 12 non-mandated elements. Views of the ring-fenced public health budget and how it was discussed, deployed and prioritised were investigated through fieldwork and surveys. Quantitative analysis described variation across local authorities and over time.

The second workstream explored changes in how preventive services were commissioned and provided, the extent of collaboration in commissioning preventive services across local authorities and CCGs and how local communities were being involved. A key question was the extent to which new commissioning responsibilities led to innovation in the provision, design and targeting of selected preventive services.

The success of the reforms also depends on public health becoming embedded within mainstream local authority services: the third workstream explored the leadership role of local authorities in promoting health and addressing health inequalities, investigating developments within and across directorates and with partners. The research also sought to identify enablers and barriers for working across a wider public health system.

### 1.1 Structure of the report and presentation of findings

This was a large and complex project. Six research reports (Appendices 1-6, see Box 1 for summary) were approved for publication on the project website during the course of the project (Available at: <https://www.york.ac.uk/che/research/public-health/commissioning-public-health-services/>) and several internal reports were completed. Rather than reproduce these findings in detail, this report is intended to:

- (a) synthesise findings by theme;
- (b) summarise methods and focus on key findings;
- (c) highlight changes between first and second phase fieldwork.

#### Box 1: Research outputs

Research Output	Description
Research Report 1 (RR1) <i>Views of national stakeholders</i> (April 2015)	Interviews with 11 national stakeholders, part of a scoping phase to inform fieldwork
Research Report 2 (RR2) <i>The public health budget</i> (September 2015)	Descriptive analysis of spend and outcomes for the public health budget
Research Report 3 (RR3) <i>Results from two national surveys: (1) Local Healthwatch and VCSE members of Health and Wellbeing Boards; (2) Voluntary, Community and Social Enterprise Organisations involved in health promotion and prevention</i> (July 2015, revised April 2016)	National surveys to Inform fieldwork from perspectives of (a) Healthwatch and (b) the VCSE sector  Response rates for the surveys were low and this limits generalisability of results
Research Report 4 (RR4) <i>Results of a national survey of Director of Public Health and Clinical Commissioning Group members of Health and Wellbeing Boards</i> (September 2015, revised April 2016)	Baseline data  Response rates for the survey were low and this limits generalisability of results
Research Report 5 (RR5) <i>Results from first phase fieldwork in 10 case study sites across England</i> (July 2016)	Analysis of interviews with 90 key stakeholders across 10 case study sites
Research Report 6 (RR6) <i>An innovation framework for public health commissioning</i> (September 2016)	Integrates findings on innovation from surveys and fieldwork

We begin by reviewing the policy and research background (section 2) before summarising methods adopted to answer the research questions (section 3). Section 4 describes patient and public involvement in the research and section 5 covers equality and diversity issues. In section 6, we present key findings related to the project's workstreams. These comprise the public health budget (6.1), followed by commissioning and providing preventive services

(6.2). Section 6.3 focuses on NHS Health Checks and childhood obesity, bringing together regression analysis of spend and outcomes with qualitative data and documentary analysis from fieldwork. Influencing and commissioning across the wider system (section 6.4) cuts across workstreams, as does innovation, described in section 6.5. Finally, section 6.6 discusses issues that arise in developing the leadership role of local government in promoting health and addressing health inequalities (workstream 3). Strengths and limitations of the study are discussed in section 7, while section 8 draws together key results and policy implications arising from the analysis. Conclusions (section 9) and dissemination plans (section 10) conclude the report.



## 2. Background: policy and research context

### 2.1 Reform rationale

The shift of public health responsibilities to local authorities, in April 2013, reflected their role in influencing social determinants of health, their links with local populations and community networks and the benefits of locating public health in a context of local democratic accountability. The Public Health White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England* (Secretary of State for Health, 2010) emphasised that through the 'radical shift' represented by the reforms, local government and local communities would be placed 'at the heart' of improving health and wellbeing. There would also be freedom to innovate in the ways that public health services were provided in the context of localism and local needs, rather than through central government performance management regimes. Local authorities were encouraged to commission through the public health budget 'a wide range of providers across the public, private and voluntary sectors and to incentivise and reward those organisations to deliver the best outcomes for their population' (para. 4.23). This could include 'grant funding' for local communities to 'take ownership of some highly focused preventive activities, such as volunteering, peer support, befriending and social networks' (ibid).

DsPH were described as 'the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors' (p.51). Local leadership through local authorities was central to the new public health system, with the aim of embedding public health across local government.

The White Paper also advocated a life course approach for improving health and tackling health inequalities ('Starting well', 'Developing well', 'Living well', 'Working well' and 'Ageing well'). This was reflected in an emphasis on 'key transitions' and on the importance of not tackling individual risk factors in isolation. New partnerships were encouraged, including with charities, voluntary organisations and community groups, 'as advocates for excluded groups and catalysts for action'. The role of the Voluntary, Community and Social Enterprise (VCSE) sector in engaging with community groups was also emphasised as part of the reforms. A subsequent national opinion survey of lead members for public health showed that, after CCGs and Health and Wellbeing Boards (HWBs), the VCSE sector was considered the main local partner for taking forward public health (Local Government Association (LGA), 2015a). The reforms were also expected to promote innovation, to include the role of the VCSE sector. As one example, the innovation strand of the Department of Health (DH) Voluntary Sector Investment Programme (DH, 2015) emphasised the importance of new approaches to 'improving people's health and well-being' (p.22).

Assessing the impact of the reforms is rendered more complex due to variation between local authorities prior to the reforms, the transfer of additional public health services post 2013, and changes in the policy and financial context which occurred over the period of the project. Public sector transformation and the need to reduce demand were also drivers for change and innovation in commissioning. These issues are discussed in turn.

### 2.2 Continuity or change?

While partnership working for public health prior to the reforms often proved difficult to achieve (Hunter and Perkins, 2014), some local authorities demonstrated successful partnership working through shared appointments of DsPH with the former Primary Care Trusts (PCTs) and multi-agency partnerships. PCTs also varied in their expenditure on public health, as reflected in the amounts transferred to local authorities through the ring-fenced

grant. Some local authorities had already demonstrated a public health ethos, reflected through strategy development, action on health inequalities or funding of public health initiatives. All these factors influenced the extent to which the reforms were perceived as reflecting continuity rather than change.

### **2.3 Transfer of additional public health services**

The ring-fenced budget was reported under 18 categories at the time of transfer. From October 2015 to March 2016, £430 million was transferred from NHS England (NHSE) to local authorities for commissioning public health services for children under five (including health visiting and the Family Nurse Partnership Programme (FNP)). As responsibility for public health programmes for children aged 5-19 had already been transferred in April 2013, local authorities became responsible for public health services for 0-19s. This opened up opportunities to integrate children's services, strengthen early intervention (Local Government Association, 2017a), and address health inequalities, supporting Marmot's policy recommendation to 'give children the best start in life' (The Marmot Review, 2010). However, it also created new public health challenges for local authorities and health partners. For example, a National Children's Bureau (NCB) report (NCB, 2015) demonstrated 'stark variations' in the health of young children (0-5) across the country according to where they lived – including variation among the most deprived areas - and highlighted the potential of a 'strategic system-wide prevention and early intervention board' such as the one being developed through devolution across Greater Manchester.

### **2.4 Financial context**

The financial context became more challenging for public health services during the project, with the confluence of unexpected in-year and ongoing annual real terms cuts in the public health budget (with a projected £600 million budget cuts planned from 2016/17 to 2020-21 (Gulland, 2017)), reduced grants to local authorities and increased demand for statutory services, in particular for adult social care. The £200 million in-year cut to the public health grant, in July 2015, was implemented irrespective of initial allocations or level of disadvantage. Prior to this, it had been announced that central government grants to local authorities would be replaced by funding through retained business rates by 2020, with further implications for disadvantaged areas.

The public health budget has come under increasing scrutiny, including through Freedom of Information requests (Iacobucci, 2014), through a National Audit Office investigation into achieving value for money through the public health grant (National Audit Office, 2014) and the related investigation of the Public Accounts Committee (House of Commons Committee of Public Accounts, 2015). The ring fence remains until 2018/2019.

### **2.5 Organisational context**

In 2017, the context for considering and prioritising preventive services was influenced by increasing concerns over risks of health and care system failure and the development of integrated approaches, including Sustainability and Transformation Plans (STPs), as a route to address some of these risks.

Key changes were influences on joint working and decision-making across the health and care system through implementation of the Better Care Fund, and through devolution, with the latter argued as one route for addressing social determinants of health through a 'place-based approach to public health leadership' (Local Government Association, 2015b). From October 2016, the 44 STPs designed to deliver the NHS 5 Year Forward View (5YFW) (NHS, 2014) increasingly influenced decision-making and the remit of public health professionals.

While STPs were subject to criticism for their lack of consistency, lack of emphasis on wider determinants of health or on engagement with stakeholders and the public (Faculty of Public Health, 2017), their impact was evident in the second phase of the project. However, the sustainability of STPs was itself questioned and a King's Fund Report noted that 'cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans' (Ham et al., 2017).

These changes were taking place in a context of ongoing calibration of the relationship between the different tiers of government and between the state and the public, which influenced the context within in public health priorities were being established.

## **2.6 Research, good practice and scrutiny**

In the four years since the reforms were implemented, there has been an upsurge of research and guidance relevant for public health in its new context. Major National Institute for Health Research (NIHR) grants (in addition to the present study) include the Policy Research Unit in Commissioning and the Healthcare System (PRUComm) study, focusing on obesity as a tracer for exploring the new public health system (Phoenix: an investigation of the public health system in England (<http://www.prucomm.ac.uk/projects/completed-projects/phoenix.html>)) and a School for Public Health Research-funded study on methods of decision-support for prioritising public health investment (Shifting the gravity of spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities (<https://www.dur.ac.uk/public.health/projects/shiftingthegravity/>)). Building on the reforms, Public Health England (PHE) and the Manchester Academic Health Science Centre developed 'Well North', working collaboratively with local authorities to develop and test innovative approaches to improving health outcomes in the most disadvantaged communities (<http://www.wellnorth.co.uk/>). A second study funded through the PRP, entitled 'Evaluating the leadership role of Health and Wellbeing Boards', is also led by Durham University (<https://www.dur.ac.uk/public.health/projects/current/prphwbs/>)

There have been regular evidence updates from PHE (see, for example, PHE and Institute of Health Equity (2014)) and ongoing research into the delivery of NHS Health Checks, (NHS Health Check Expert Scientific and Clinical Advisory Panel, 2017), including exploration of innovative approaches, and an annual conference with results disseminated through a collaborative resource for the Health Check Programme (<http://www.healthcheck.nhs.uk/>).

In order to build on the strategic review of health inequalities in England post-2010 (the Marmot Review, 2010), DH commissioned a suite of reports on social factors influencing health and health equity, intended to support policy making, including at a local level (Roberts, 2015a; Allen and Donkin, 2015; Roberts, 2015b). More recently, PHE published a series of 'Practice Resource' papers to help local authorities address health inequalities. These resources review the Social Value Act, ways of reducing social isolation and routes for improving health literacy (<https://www.gov.uk/government/collections/local-action-on-health-inequalities-practice-resources>).

The long-awaited childhood obesity strategy (Childhood obesity: a plan for action, August 2016, updated January 2017) centred on sport and breakfast clubs, a soft drinks industry levy (sugar tax) and voluntary action by the food and drinks industry to reduce sugar in the main sources of sugary foods. It did not consider curbs on advertising or promotions of unhealthy food.

Reflecting the new public health role of local authorities, the LGA has published multiple Briefing and Resource Sheets since the reforms. These span: broad approaches to public health and prevention (health in all policies and the integration agenda) and specific services (such as health checks); the importance of partnerships for public health (including with faith groups, pharmacies and businesses); and the needs of specific geographical communities or groups. They also address specific public health issues (such as health inequalities, and healthy weight) and wider workforce issues.

Innovation is highly valued in a local authority context and the move of public health (back) to local government is in itself an important innovation bringing with it greater exposure to local democratic pressures and forces, as well as new dialogues. Wider and ongoing changes in the nature of the public sector and local public services mean that cross-disciplinary working has become the norm in local government. There are also willing partners in other services (e.g., fire and rescue) that may not have existed to the same extent in the past. While VCSE organisations were seen as a source of innovation, three surveys of local Healthwatch and VCSE members of HWBs, as well as of VCSE members interested in engaging with the HWB, showed evidence of underutilisation of the VCSE sector by partners in health and social care, diminishing of influence as the commissioning cycle progressed and the need for clearer routes of engagement and better working across Healthwatch and local voluntary organisations.<sup>1</sup> (Regional Voices 2014a; 2014b; 2015)

Of particular interest for innovation is a series of LGA publications bringing together case studies illustrating ‘transformation’ in local authority services profiling innovative approaches to public health being taken by local government (LGA and PHE, 2014a; LGA, 2014b; LGA, 2015c; LGA 2016; LGA, 2017b). These include: examples of ‘whole council’ approaches to public health; health impact assessment (HIA) of local policies; integrated health and wellbeing services; involving other council directorates in delivering improved outcomes; and DsPH taking on wider roles in the council (see RR6 for summary).

‘Public health transformation, four years on’, focuses on ‘health in all policies’ and on maximising the potential of a local authority workforce in promoting health. The foreword emphasises that ‘the renewed public health function of local government has only just got started and it cannot continue to maximise its role at the heart of councils while continually retrenching to make budget reductions’ (LGA, 2017b, p.3). Nevertheless, the report highlighted growing confidence, greater integration of services with examples of progress in mental health and child health services, increased use of technology, influences on planning and the built environment and on the impact of worklessness.

What constitutes innovation in public health policy and practice is also attracting increased research interest (see, for example, Hancock, Barr and Potvin, 2015). In a study which attempted to define innovation in public health, Fung, Simpson and Packer (2010) note that ‘innovation in public health has not been defined’ and, based on a quasi-Delphi study (largely of public health professionals), concluded that:

*Innovative public health interventions (PHIs) are generally new and different to established interventions. They should be equitable, applicable to all in a population, cost-effective and may address health determinants in the non-health sector of society. A good evidence base is ideal but sometimes it may be necessary to consider PHIs lacking evidence.*

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<sup>1</sup> Survey findings available at <http://www.regionalvoices.org/hwb-reps/survey>.

This emphasis on equity, social determinants of health and on population-wide interventions are discipline-specific elements of public health which influence how innovation in public health commissioning is to be understood.

Recent and ongoing research studies reflect many of the concerns raised in an initial enquiry into new public health responsibilities (House of Commons Communities and Local Government Committee, 2013), namely fragmentation and conflicting responsibilities, lack of power of HWBs and dangers of public health being squeezed out by the agenda for integrating health and social care. A subsequent enquiry (House of Commons Health Committee, 2016) welcomed the reforms as 'largely positive' but also highlighted fragmentation and problems in data sharing, issues related to health protection (in some areas), financial pressures and the issue of 'unacceptable variation' in outcomes. There were tensions between the evidence base and political priorities in decision-making and a need to include health as a material consideration in planning and licensing decisions. The committee recognised the situation as 'evolving'. The impact of the reforms on the role and influence of the public health profession, and on public health leadership and the capacity of DsPH to influence investment continues to be debated (Association of Directors of Public Health, 2014; Royal Society for Public Health, 2014; Willmott et al., 2016).

### 3. Methods

Mixed methods, combining qualitative and quantitative approaches, were used for each workstream. Research questions were investigated through four national surveys; data analysis of spend and health outcomes with a particular focus on NHS Health Checks and childhood obesity; in-depth study of 10 case study sites across England through two phases of fieldwork, carried out one year apart; and analysis of national datasets. An iterative approach to developing research instruments was adopted and findings from an extensive scoping phase (interviews with national stakeholders and national surveys) informed subsequent research. Similar themes were explored through survey questions and interview schedules, allowing for integration of results. Box 2 summarises, by workstream, research questions arising from the research objectives and the methods used to address them. More detailed accounts of methods adopted for different elements of the research can be found in the relevant research reports (Appendices 1-6).

#### Box 2: Research questions for the three workstreams of the study

##### ***Workstream 1: new budgetary responsibilities***

###### Research questions:

- (a) How has the ring-fenced public health budget been deployed and pooled with other local authority services?
- (b) How does deployment of the budget relate to public health outcomes?

###### Methods:

- Descriptive analysis of nationally available routine data including quarterly and annual public health returns to the DCLG, illustrating variation in spend in relation to selected public health outcomes (RR2);
- Analyses by case study site of deployment of the budget across public health reporting categories in relation to selected outcomes. This informed fieldwork selection and a more detailed analysis by case study site was carried out prior to fieldwork;
- Analysis of outcome data from national indicator sets in relation to spend; regression analyses of data from the National Child Measurement Programme (NCMP) and NHS Health Check programme;
- Quantitative analysis of two national surveys of DPH and CCG members of HWBs (See RR4 for analysis of Survey 1), carried out one year apart. The national surveys sought views over the ring-fenced public health budget, deployment of the budget in 2014-2015 (Survey 1) and 2015-16 (Survey 2), and funding for specific public health services for the initial 18 local authority public health budget reporting categories;
- Quantitative analysis of the survey of Healthwatch and VCSE sector members of HWBs, which sought views over knowledge of how the public health budget was deployed;
- Qualitative analysis of (1) interviews with national stakeholders (n=11) carried out as part of the scoping phase; (2) interviews with key stakeholders in first and second phase fieldwork (n=111). Through fieldwork we analysed stakeholder views on key aspects of the budget and its deployment over time to include: how and where the budget was discussed and scrutinised; factors influencing changes in the ways it was used; pooling arrangements; cross-directorate use of the budget; advantages or disadvantages of maintaining the ring fence; and the distinction between mandated and non-mandated services. A detailed account of first phase fieldwork is included in RR5;
- Qualitative analysis of comments generated in national surveys.

##### ***Workstream 2: Responsibility for commissioning preventive services***

###### Research questions:

- (a) Has the shift in public health responsibilities been reflected in changes in commissioning of selected preventive services and in their uptake?
- (b) To what extent are HWBs and CCGs collaborating over commissioning preventive services?

(c) Have new public health responsibilities led to innovation in the use of providers, in co-design, in targeting strategies and in models of provision?

Methods:

- Qualitative analysis of first and second phase interviews (n=111) carried out with stakeholders in 10 case study sites and of interviews (n=11) with national stakeholders;
- Quantitative analysis of two surveys of DPH and CCG members of HWBs, carried out one year apart;
- Analysis of a national survey of Healthwatch and VCSE members of HWBs;
- Analysis of a national survey of VCSE organisations involved in health promotion and prevention;
- Documentary analysis, including follow up of documents highlighted by interviewees in first and second phase interviews;
- Non-participant observation of HWB meetings;
- Qualitative analysis of comments provided by survey respondents.

***Workstream 3: The leadership role of local authorities in promoting health and addressing health inequalities***

Research questions:

(a) Which factors influence effective public health decision-making across local authorities?

(b) What are the enablers and barriers to public health commissioning and how can the system be improved?

Methods:

- Quantitative analysis of national surveys of DPH and CCG members of HWBs;
- Qualitative analysis of:
  - comments provided in national surveys;
  - interview data from case study sites;
  - interviews with national stakeholders.

### **3.1 Scoping phase: interviews with national stakeholders**

Interviews with national stakeholders (n=11) were designed to identify key issues to be addressed in the 10 case study sites, inform research instruments, explore criteria for the selection of sites, and recommend dissemination strategies (see RR 1). They were also intended to inform the development of the first of two national surveys of DPH and CCG members of HWBs.

The sample included senior representatives from organisations (n=8) with a national perspective on aspects of the public health reforms, two academics with a national perspective on issues related to the study, and a former DPH, who also piloted the schedule. The organisations included: the Faculty of Public Health; the Association of Directors of Public Health; Healthwatch England; the LGA (two interviews); the Centre for Public Scrutiny; NHS Clinical Commissioners; and a national voluntary sector organisation. Four interviewees also had a local role (for example, as members of HWBs) and one interviewee was leader of a council. All interviews were recorded and transcribed by a professional agency and a thematic analysis was carried out by two members of the project team.

### **3.2 Public health budget analysis**

***Quantitative descriptive analysis of spend and outcomes***

We conducted a descriptive analysis of routinely available expenditure and outcomes data (RR2 – see Box 1). The aim was to provide a high-level overview of how spend on different categories of the public health budget varied across local authorities and over time. Variations in spend were also compared with relevant outcome indicators.

Profiles of each local authority at baseline (2013/14) were derived to help inform the selection of case study sites. The profiles included spend, outcomes, local authority class (type), ethnicity, level of disadvantage and rurality.

### ***Regression analysis of spend and outcomes***

During the tendering process, DH requested an in-depth exploration of quantitative evidence of a causal relationship between spend and outcomes. Using data covering the first three years of the public health reforms, we conducted regression analyses on two topics: (1) the NHS Health Check programme; and (2) childhood obesity. The DH provided steers on the choice of topics, to avoid overlap with other studies shortlisted for commissioning as part of the (then) Health Reform Evaluation Programme tender.

The analysis of the NHS Health Check programme sought to evaluate the effects of local authority spend on three intermediate outcomes: invitation rates; coverage rates (attendance as a proportion of the eligible population); and uptake rates (attendance by those invited). All data were at local authority level and were sourced from routinely available datasets. Choice of control variables was informed by a literature review and included predisposing, enabling and need factors. Negative binomial panel models were used because of overdispersion of the outcome variables, and findings were tested using a series of robustness checks. An evaluation of the impact of the reforms on health inequalities was prohibited by a lack of ward-level data on health check invitees and attendees. Further details of the methods are in sub-section 6.3.1.

The analysis of childhood obesity also used negative binomial models to test whether spend in the first year (or in the first two years) of the reforms was associated with levels of childhood obesity in 2015/16.

The outcome variable - defined as the proportion of children within the local authority who were overweight or obese - was sourced from the NCMP which collects data on school children in Reception year (aged 4 to 5) and Year 6 (age 10 to 11). We used local authority level data. Per capita spend on childhood obesity in earlier years was the principal explanatory variable (sourced from local authority revenue returns data). The model also included expenditure on children's physical activity, and on the public health children's programme.

The models also controlled for local authority level factors: local authority class (type), the prevalence of overweight and obese children in 2013/14, the proportion of children in a local authority who were from minority ethnic groups, and the number of fast-food outlets per 1000 persons. Further details of the methods are in sub-section 6.3.2.

### **3.3 Fieldwork: in-depth analysis of 10 case study sites**

Fieldwork was carried out in 10 case study sites across England, as planned (see RR 5). Site selection was informed by the scoping phase of the study (see RRs1-4), advice of the EAG, and by criteria such as level of disadvantage, rurality, geographical spread, ethnicity and evidence of innovation. We also sought to include multi-district authorities and authorities under different political control. Table 1 shows that our sample of 10 sites largely reflected our selection criteria. All areas of England were represented, with the exception of the North East.



**Table 1: Case study sites**

Site	Unitary	Rural	Pop over 300,000	Deprivation level (1 to 5; 1 is most disadvantaged)	Political control	CCGs
A	No	Yes	Yes	4	NOC	Multiple
B	Yes	No	Yes	2	Lab	1
C	Yes	No	No	3	Con	1
D	Yes	No	Yes	2	Lab	Multiple
E	No	Yes	Yes	5	Con	Multiple
F	Yes	No	No	2	Lab	1
G	Yes	No	Yes	1	Lab	1
H	Yes	No	No	1	Lab	1
I	No	Yes	Yes	5	Con	Multiple
J	Yes	No	No	2	Con	1

Table 2 shows the recruitment of interviewees for first and second phase fieldwork (actual titles may differ). For the first phase (October 2015 to May 2016), we aimed for 10 interviews per site, to include the DPH, Chief Executive (CE), Service and Executive Directors (Adult Social Services/Children’s Services/People/Communities), a CCG member of the HWB (usually Vice or Co-Chair), HWB Chair (Elected Member), Health Scrutiny Committee Chair (Elected Member), NHSE member of the HWB, Healthwatch Chair and a representative from the VCSE sector. VCSE sector representation on HWBs is optional and variable: where the VCSE sector was not represented (five sites), a representative from a local umbrella body was invited to participate. There were differences in sample size between sites to reflect multi-district authorities (where a district council representative on the HWB was also invited (n=3)), and additional Elected Member representation on the HWB, where relevant (n=3). Due to reconfiguration of management structures into a fewer number of directorates, interviewees in some sites were responsible for both adult and children’s services and, as shown in Table 2, alternatives were sometimes suggested to reflect specific commissioning responsibilities.

Of the eight HWB chairs who agreed to be interviewed, three were either Leaders or Deputy Leaders of the council. HWB chairs held a wide range of portfolios, including the NHS, community engagement, community sector, adult social care, children and families, education and skills, community wellbeing and older people. Of the three additional HWB Elected Members who were interviewed, one had a specific portfolio for public health. In other cases, portfolios covered a combination of adults, children, older people and health and wellbeing. We also interviewed nine Elected Members who were Chairs of the Health Scrutiny Committee. Of the seven CEs interviewed, two were also members of the HWB. Of the seven CCG representatives interviewed, all were HWB members: four were also Vice-Chairs of their HWB and one was a joint chair.

Brief snapshots for each case study site were prepared beforehand to provide a context.

Second phase interviews (n=21) were carried out with a sub-sample across the 10 sites one year after first phase interviews (November 2016 to April 2017). Interviewees included the DPH (where in post) for each site but the role of additional interviewees varied. Overall, they reflected the range of roles achieved in first phase interviews.

A generic interview schedule was modified to reflect interviewee roles and responsibilities. Interviews were audio-recorded with the permission of the interviewee and transcribed

verbatim by an external transcription agency. Initial coding was undertaken (by LMJ) using NVivo 10 software to organise the data into nodes based on a framework developed from the interview schedule. Other team members (LM, SV, KM) independently analysed the interview transcripts to identify emergent themes. The results were merged through repeated discussions, and verified by sharing draft reports with the EAG (which included a DPH and representation from NHS England, the LGA, Healthwatch and the VCSE sector).

**Table 2: Recruitment for fieldwork (Phases 1 and 2)**

Interviewees	Case study site										Total
	A	B	C	D	E	F	G	H	I	J	
HWB Chair	R	R RT2	R	RT	D	D	RT RT2	R	R	R	<b>10</b>
DPH	R RT2	R RT2	R RT2	R R2	R RT2	R R2	R RT2	R RT2	R	R RT2	<b>19</b>
CCG (HWB member)	RT	R	D	R	R	R	R	R RT2	D	D	<b>8</b>
CE	R	R	R RT2	D	R	R	D	R	D	R	<b>8</b>
Director (Children's Services)	R R2	R	R	A	A	A	R	R	D	RT	<b>10</b>
Director (Adult Services)	R	R	RT	R R2	(A)	R	RT RT2	(R)	A	RT	<b>11</b>
Healthwatch Chair/CE	R	R	D	R	R	A	R	D	RT	A	<b>8</b>
Health Scrutiny Committee Chair	R R2	D	R	RT	R	R	RT	R	R	RT2	<b>10</b>
VCSE sector (HWB member)	N/A	N/A	RT	N/A	N/A	R	R	R	R	N/A	<b>5</b>
VCSE (other)	RT	R	N/A	R/T	R RT2	N/A	N/A	N/A	N/A	R	<b>6</b>
NHSE (HWB member)	RT	D	RT	R	R	R	D	RT	D	D	<b>6</b>
Elected Member (Additional HWB member)	R	N/A	N/A	N/A	N/A	R	N/A	N/A	N/A	R	<b>3</b>
District Councillor (HWB member)	RT	N/A	N/A	N/A	R	N/A	N/A	N/A	R R2	N/A	<b>4</b>
Additional Interviewees				RT	RT				R2		<b>3</b>
<b>Total</b>	<b>15</b>	<b>10</b>	<b>10</b>	<b>12</b>	<b>12</b>	<b>11</b>	<b>11</b>	<b>11</b>	<b>9</b>	<b>10</b>	<b>111</b>

Bracket signifies multiple responsibilities; R: Recruited (face to face interview); RT: Recruited (telephone interview); D: Declined; N/A: Not applicable or post not filled; A' refers to additional interviewees, whether via delegation or recommendation. A second Elected Member of the HWB was invited, depending on the portfolio held by the HWB Chair.

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Comparative case study analysis draws on fieldwork and documentary analysis and on summaries of each case study in relation to key project themes.

### **3.4 Documentary analysis**

Documentary analysis included separate analysis of key documents for each site (DPH annual reports, STPs, selected committee papers (Health Scrutiny committees and HWBs), CCG reports and strategies for healthy weight in children). Relevant documentation was also identified in both first and second phase interviews and documents were followed up with individual sites by the research team.

### **3.5 National surveys**

The following national surveys were carried out during the course of the project.

- Two national surveys of DPH and CCG members of HWBs (2015 and 2016);
- National survey of Healthwatch and VCSE sector members of HWBs (2015);
- National survey of VCSE organisations involved in health promotion and prevention (2015).

Bristol Online Surveys (BOS) was used to produce the survey tool in each case. Surveys are summarised in turn.

#### ***Surveys of DPH and CCG members of HWBs***

*Survey 1:* findings from the scoping phase were taken into consideration when formulating the questions, which were piloted. A database of DsPH was updated and a new database of the most senior CCG members of HWBs created. Personalised survey invitations (n= 287) were sent out in early August 2015. Two reminders were issued. Most questions were multiple choice but respondents had the opportunity to provide comments for 13 questions and answers were free text only for four additional questions (see RR4).

*Survey 2:* this replicated the first survey to facilitate comparison and was sent out at the end of June 2016. Three reminders were sent to non-respondents and the survey closed on 31<sup>st</sup> August 2016.

#### ***National survey of Healthwatch and VCSE sector members of HWBs***

Survey questions were amended in the light of three pilots. Surveys were cascaded by eight regional coordinators for Regional Voices (a strategic partner of DH) through their databases of Healthwatch and VCSE members of HWBs and wider VCSE networks. Through the support of a Healthwatch England member of the project EAG, local Healthwatch members were also contacted via a newsletter and on the Healthwatch intranet (see RR3).

#### ***National survey of VCSE organisations involved in health promotion and prevention***

The survey was piloted twice. Regional Voices cascaded the survey through their databases of Healthwatch and VCSE members of HWBs and wider VCSE networks (see RR3).

Healthwatch and VCSE surveys each included questions on the impact of the public health reforms, funding, influences on commissioning preventive services, public involvement, innovation, and enablers and barriers to greater involvement of the VCSE sector in prevention. The survey of VCSE organisations involved in health promotion and prevention was shorter, included more open questions and focused on approaches to, and examples of, innovation while the survey of Healthwatch and VCSE members of HWBs included more questions on commissioning, reflecting the strategic role of HWB members.

Response rates for all four surveys were low and generalisation from the findings is, therefore, limited.

Section 6 brings together results from both qualitative and quantitative analyses in relation to main themes of the study, drawing on all the elements summarised above.

## 4. Patient and public involvement in the research

The study involved the public in key stages of the research cycle, including identifying and prioritising research topics, designing and managing the research, analysing and interpreting results and dissemination of findings. This process was facilitated by Joanne Smithson (CI), Health and Wellbeing policy lead (2011-14) and then Associate (2014-present) for Voluntary Organisations' Network North East (VONNE), a regional infrastructure body for the voluntary and community sector (VCS) and by the participation of representatives from Healthwatch England and the British Lung Foundation in the EAG for the study. The latter met at regular intervals throughout the project to discuss research findings and dissemination strategies.

In order to develop research instruments, the study involved an extensive scoping phase which included: (a) interviews with stakeholders including Elected Members, a local Healthwatch representative and a representative from Regional Voices; (b) a survey of Healthwatch and VCSE members of HWBs; and (c) a survey of VCSE organisations involved in health promotion and prevention. Both surveys were amended in the light of feedback (from three pilots for (b), including two from local Healthwatch and two pilots for (c)) before being cascaded by eight regional coordinators for Regional Voices. The survey of VCSE organisations was distributed to a wide range of VCSE organisations involved in delivering services or interventions to improve health and reduce health inequalities. The surveys included many open questions and generated extensive comments. Through the support of the Healthwatch England member of the EAG, local Healthwatch members were also contacted via a newsletter and on the Healthwatch intranet. Results from the surveys were discussed by the EAG and influenced topics included in interview schedules used in fieldwork. Fieldwork, survey results and documentary analysis were also reviewed from a VCSE perspective.

While involvement of the VCSE sector and Healthwatch in the scoping phase was a key influence on study design, public involvement in decision-making is integral to democratically elected local authorities and VCSE organisations play a key role in addressing health inequalities. Our sampling strategy for case study sites included VCSE organisations, local Healthwatch and a range of Elected Members (Health Scrutiny Chairs, HWB chairs and additional Elected Members where relevant). Where the VCSE was not represented on HWBs, we identified relevant local VCSE organisations and interviewed a representative. In this way, the project aimed to explore the influence of the public in decision-making related to public health as well as relationships between HWBs, commissioners and wider community networks. Public Voice was explored through separate investigations of co-design in relation to specific preventive services and for different age groups, to include an assessment of the extent to which this had been influenced by the public health reforms. This was explored through the four national surveys as well as through fieldwork, as were wider topics of community involvement in priority-setting, addressing health inequalities and in commissioning preventive services. While these activities form part of the research plan, rather than reflecting patient or public involvement in research design, they also reflect the fact that public involvement is inherent in local authority decision-making across directorates and was integral to all aspects of the research study.

The dissemination of the project will be facilitated through Regional Voices, a nationwide partnership of regional voluntary sector networks which champion and support the involvement of local voluntary and community organisations in developing policy and designing and delivering services. Lay representatives and members of the VCSE sector participated in the national conference for the project, which included a facilitated breakout

group on the involvement of the VCSE sector in public health services. Joanne Smithson led on these aspects and as PPI lead for the project will be disseminating results across networks, summarising research results in clear, user-friendly language.

## 5. Equality and diversity issues

The research was carried out in accordance with Durham University's Diversity and Equality Policy and research instruments were subject to the university's ethical review processes.

Issues related to equality and diversity were reflected in the PPI strategy and in research questions investigating how preventive services reflect the diversity of local populations, including how the VCSE sector engaged locally with commissioners and public health teams. The case study sites were selected to reflect a range of factors such as deprivation, rurality, ethnicity and political affiliation.

The research investigated the extent to which local authorities use knowledge of their local communities to provide preventive services that are acceptable and accessible to different groups within the population. The public health reforms are partly premised on the more effective role that local authorities can play in this area. Devising services which are acceptable to different groups is an integral part of providing effective preventive services which do not have the unintended consequences of increasing health inequalities, through differential uptake.

The regression analyses of NHS Health Checks and of childhood obesity both explored the impact of gender, ethnicity, rurality and deprivation on outcomes (for details, see subsection 6.3).

## 6. Key findings

This section of the report reports key findings by workstream: the public health budget (6.1); commissioning and providing preventive services (6.2), with separate analyses of spend and outcomes for NHS health checks and childhood obesity (6.3) and commissioning across a public health system (6.4). The third workstream, the public health leadership role of local authorities is discussed in sub-section 6.5. As an overarching theme, innovation is discussed in sub-section 6.6 and, in greater detail, in RR6. Discussion of health inequalities and community involvement is integrated within all sections with more detailed analysis in sub-section 6.2.6.

### 6.1 The public health budget: how it is used, prioritised and scrutinised

#### 6.1.1 Introduction

The ring-fenced public health budget was estimated from preventative spend in PCTs (itself highly variable) and a fair shares formula. Transferred to upper-tier and unitary local authorities in April 2013, it initially included 18 budget reporting categories to ensure a ‘transparent accounting process’ (DH, 2013). The 18 reporting categories were subsequently extended to 20, then to 24, to reflect the transfer of 0-5 children’s services (prescribed) and additional non-prescribed functions: preventing and reducing harm from drug misuse in adults; non-prescribed children’s services (0-5); health at work; and public mental health (the latter two drawn from the original ‘Miscellaneous’ category). As before, the 2016 ‘Miscellaneous’ category was very broad, covering ‘general prevention’ and ‘other public health services’ (DH, 2016). Table 3 shows how the reporting categories evolved during our study period, with a total of 30 distinct categories used.

Ring-fenced budgets are unusual in a local authority context, largely limited to education and public health. The removal of the ring fence was often anticipated but in 2017, a further extension until 2018/19 was announced. The budget allocation was subject to an allocative formula with gradual movement towards target allocations. However, the Treasury announced an in-year cut to the budget in June 2015 (6.7% applied equally to each authority) and the 2015 Spending Review identified further cuts of 2.2% (2016/17) and 2.6% (2017/18). These reductions were weighted neither by deprivation nor by historical allocation. Studying the ring-fenced public health budget inevitably prompted views over the impact of cuts specific to the budget and of concurrent reductions in local authority funding.

**Table 3: Overview of the public health expenditure reporting categories, 2013/14 to 2016/17**

	Prescribed Function (mandated )	2013 /14	2014 /15	2015 /16	2016 /17
361	<b>Sexual health services</b> - STI testing and treatment	Yes	✓	✓	✓
362	<b>Sexual health services</b> – Contraception	Yes	✓	✓	✓
363	<b>Sexual health services</b> - Advice, prevention & promotion	No	✓	✓	✓
365	<b>NHS health check programme</b>	Yes	✓	✓	✓
366	<b>Health protection</b> - LA role in health protection	Yes	✓	✓	✓
368	<b>National child measurement programme</b>	Yes	✓	✓	✓
370	<b>Public health advice</b>	Yes	✓	✓	✓
371	<b>Obesity</b> – adults	No	✓	✓	✓

372	<b>Obesity</b> – children	No	✓	✓	✓	✓
373	<b>Physical activity</b> – adults	No	✓	✓	✓	✓
374	<b>Physical activity</b> – children	No	✓	✓	✓	✓
376	<b>Substance misuse</b> - Drug misuse – adults	No	✓	✓	✓	
376	<b>Substance misuse</b> - Treatment for drug misuse in adults	No				✓
377	<b>Substance misuse</b> - Alcohol misuse – adults	No	✓	✓	✓	
377	<b>Substance misuse</b> - Treatment for alcohol misuse in adults	No				✓
378	<b>Substance misuse</b> - (drugs and alcohol) - youth services	No	✓	✓	✓	
378	<b>Substance misuse</b> - Preventing and reducing harm from drug misuse in adults	No				✓
379	<b>Substance misuse</b> - Preventing and reducing harm from alcohol misuse in adults	No				✓
380	<b>Smoking and tobacco</b> - Stop smoking services and interventions	No	✓	✓	✓	
380	<b>Substance misuse</b> - Specialist drug and alcohol misuse services for children and young people	No				✓
381	<b>Smoking and tobacco</b> - Wider tobacco control	No	✓	✓	✓	
381	<b>Smoking and tobacco</b> - Stop smoking services and interventions	No				✓
382	<b>Smoking and tobacco</b> - Wider tobacco control	No				✓
383	<b>Children 5–19 public health programmes</b>	No	✓	✓	✓	✓
384	<b>Miscellaneous public health services</b> - Children's 0–5 services	Yes			✓	
384	<b>Mandated 0-5 children's services</b>	Yes				✓
385	<b>Miscellaneous public health services</b>	No	✓	✓		
385	<b>Miscellaneous public health services</b> - Children's 0-5 services – Other	No			✓	
385	<b>All Other 0-5 children's services</b>	No				✓
386	<b>Miscellaneous public health services</b> – other	No			✓	
386	<b>Health at work</b>	No				✓
387	<b>Public mental health</b>	No				✓
389	<b>Miscellaneous public health services</b> – other	No				✓
390	<b>TOTAL PUBLIC HEALTH</b>		✓	✓	✓	✓
		8	18	18	20	24

### 6.1.2 Studying the public health budget

The first workstream analyses changes in how the ring-fenced budget was deployed, bringing together quantitative and qualitative methods. We begin by summarising views of national stakeholders, carried out as part of the scoping phase, followed by analyses of planned and actual expenditure and of how expenditure varied over time. Sub-section 6.1.3 reviews five main themes emerging from the study and sub-section 6.1.4 reviews pooled arrangements.

#### ***Setting the scene (1): views of national stakeholders***

Interviews with national stakeholders, carried out as part of the scoping phase, identified key themes which were further explored in case study sites. These included the allocation formula, the influence of Elected Members, a focus on improving local public health outcomes and moving away from a narrow focus on the public health budget to the entirety



of the local authority budget. The distinction between mandated and non-mandated services was questioned. These are discussed in turn.

Reporting public health spend against the original 18 categories was considered an advance on the opacity of public health spending in the NHS, but there were criticisms of the allocation formula, influenced by deprivation and life expectancy, while the bulk of the budget was spent on demand-led services (such as substance misuse and sexual health services) mainly used by younger people.

While initial deployment of the budget had been influenced by historical spend and requirements of mandatory services, in future, the main influence was likely to be the 'political strategy of the council' and the views of Elected Members, in contrast to the centrally determined priorities of the NHS. It was argued that public health funds being deployed for other purposes was not new, although post-2013 the demands were not from deficits in acute care funding as in the NHS, but for helping to manage increased demand for social care in local authorities.

Others highlighted the importance of addressing major public health challenges and of spending the budget on what could make the greatest difference locally. Identifying whether spending was having the expected outcomes was described as going 'to the heart of the scrutiny and accountability agenda'. Nevertheless, return on investment could prove difficult to demonstrate over the shorter-term, which begged the question of how public health spend was to be prioritised.

National stakeholders pointed out that the debate needed to move away from a focus on the public health budget - 'the 4%' - which should not be viewed in isolation from the rest of local authority spend. It was argued that 'this debate tends not to occur in the most innovative local authorities'. Instead it was argued that the public health budget should be used as a catalyst or as 'seed money' to shift the major spend of local authorities and that the entirety of the local authority budget should be maximised for public health benefit across the services local authorities provided.

There were different views over the distinction between mandated and non-mandated public health services. Some national stakeholders did not consider it a helpful division, given variation in how authorities met mandatory requirements. Others felt that local relevance was also important. However, the distinction could protect essential services that were not high profile or might not be viewed as 'vote winners', as well as those areas where the evidence base had been contested, such as NHS Health Checks. There was a degree of irony in the fact that follow-up services were not mandatory.

### ***Setting the scene (2): Data analysis of spend***

RR2 describes how local authorities spent their 2013/14 public health budgets across all the public health reporting categories in relation to selected outcomes. Adult drug misuse was the largest share of spend (21.2%, £535m), followed by testing and treatment for sexually transmitted infections (15.2%). Almost 14% of spend was classified in the 'Miscellaneous' category.

Table 4 provides details of trends in national expenditure broken down by the 30 reporting category labels used in the DCLG accounting returns. The table shows planned (revenue account budget, i.e. estimated expenditure) and actual (revenue outturn) spend for the four years.

Overall, areas in which local authorities spent less than planned included sexual health services (advice, prevention and promotion), NHS Health Checks, health promotion, adult obesity, and wider tobacco control. Unsurprisingly, local authorities consistently spent less on the miscellaneous categories than they had planned to do.

The areas in which local authorities spent more than planned were usually related to children's services. For example, in 2013, spend on children's physical activity was more than double the amount planned. Other categories where local authorities spent at least 25% more than planned included the NCMP (2014), substance misuse in youths (2013), and miscellaneous spend on non-mandated services for under 5s (2015). In 2013, spend on adult physical activity was 47% higher than the planned amount, but this fell to 7% higher in 2014, and in 2015 fell to 2.4% below planned levels.

Table 4: Public health expenditure (£m): planned vs. actual by reporting category, 2013-2016

	2013		2014		2015		2016	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
SHS – STI	£366.9	£382.4	£383.5	£379.2	£390.0	£366.0	£360.3	.
SHS – Contraception	£155.6	£178.6	£184.1	£190.7	£191.2	£193.5	£174.5	.
SHS - Promotion/prevention/advice	£114.1	£83.9	£103.8	£86.1	£82.7	£71.7	£76.5	.
NHS Health Checks	£86.2	£56.4	£85.3	£63.3	£81.4	£60.0	£69.9	.
Health protection	£40.8	£34.0	£37.5	£38.8	£43.0	£33.5	£37.6	.
NCMP	£22.5	£23.6	£19.1	£26.6	£29.2	£21.5	£27.7	.
Public health advice	£64.5	£64.2	£68.5	£62.1	£73.3	£55.7	£55.0	.
Obesity – adults	£68.2	£59.3	£72.5	£63.1	£71.9	£61.3	£58.6	.
Obesity – children	£28.5	£29.2	£35.7	£36.6	£39.4	£40.4	£40.8	.
Phys. activity – adults	£31.3	£46.0	£58.9	£62.8	£71.1	£69.4	£61.0	.
Phys. activity – children	£11.0	£22.9	£16.9	£32.2	£24.8	£26.9	£25.1	.
SM Drug – adults	£568.8	£532.4	£562.7	£541.3	£558.9	£490.0	.	.
SM Drug, treatment – adults	.	.	.	.	.	.	£408.5	.
SM Alcohol – adults	£204.1	£190.4	£200.2	£201.1	£208.1	£229.5	.	.
SM Alcohol, treatment – adults	.	.	.	.	.	.	£183.3	.
SM Drugs & alcohol – youth	£55.0	£70.8	£69.5	£66.7	£62.5	£47.8	.	.
SM Drug harm – adults	.	.	.	.	.	.	£72.2	.
SM Alcohol harm – adults	.	.	.	.	.	.	£38.8	.
SM Specialist services - children & youth	.	.	.	.	.	.	£56.5	.
Smoking - Stop smoking	£136.3	£128.1	£140.5	£119.6	£141.4	£111.2	£105.0	.
Smoking - Wider tobacco control	£22.1	£18.9	£19.2	£14.7	£18.6	£13.5	£15.6	.
Children 5-19 PH programmes	£230.8	£241.6	£259.5	£267.1	£276.3	£256.0	£265.0	.
Mandated - Children 0-5	.	.	.	.	.	.	£746.7	.

	2013		2014		2015		2016	
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
All other services - Children 0-5	.	.	.	.	.	.	£148.9	.
Misc. PH serv., prescribed - Children 0-5	.	.	.	.	£378.3	£402.1	.	.
Misc. PH serv., non-prescribed - Children 0-5	.	.	.	.	£99.7	£131.9	.	.
Misc. PH services	£492.7	£345.4	£531.2	£484.6	.	.	.	.
Misc. PH services – other	.	.	.	.	£479.7	£470.3	£391.8	.
Health at work	.	.	.	.	.	.	£29.7	.
Public mental health	.	.	.	.	.	.	£47.0	.
<b>Total public health</b>	<b>£2,699</b>	<b>£2,508</b>	<b>£2,849</b>	<b>£2,737</b>	<b>£3,321</b>	<b>£3,152</b>	<b>£3,496</b>	.

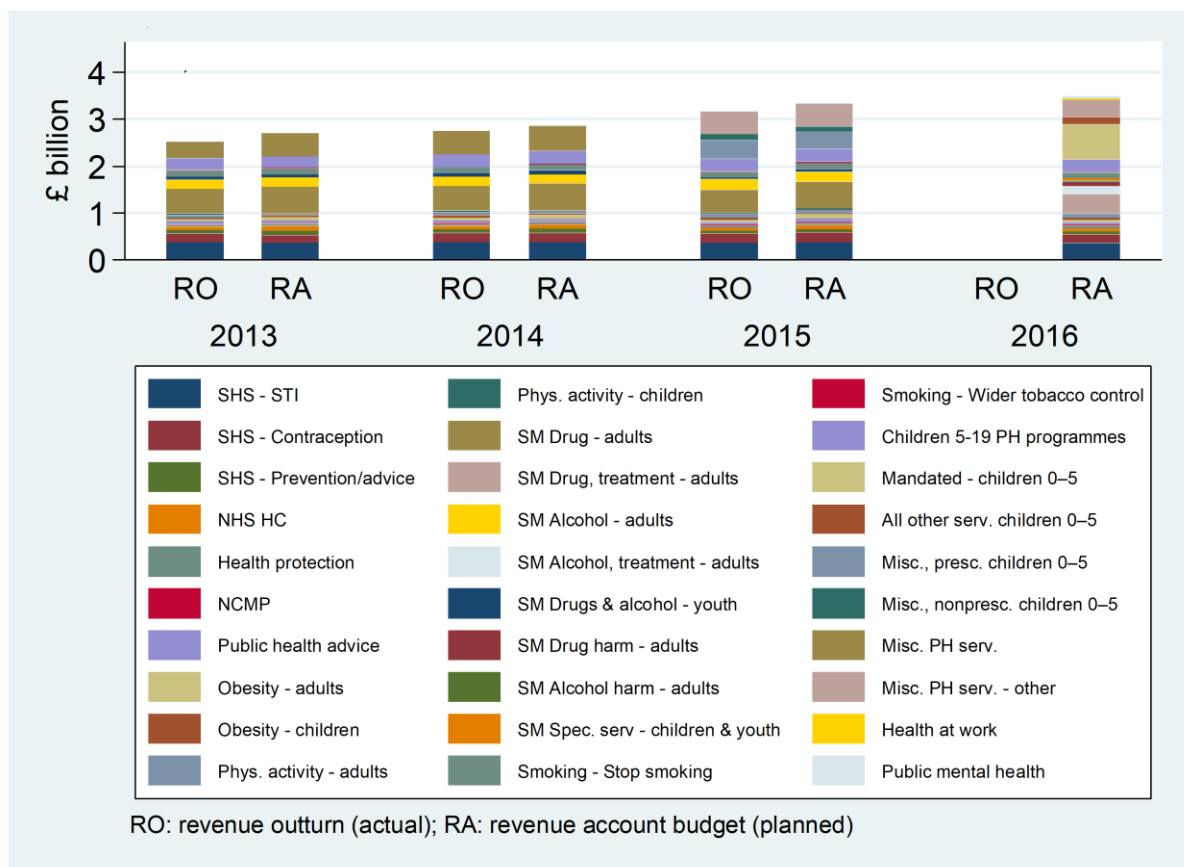
Notes:

SHS: sexual health services; STI: sexually transmitted infection; NCMP: national child measurement programme; SM: substance misuse; PH: public health  
Spend is reported by the 30 categories used during 2013- 2016. Actual (outturn) expenditure for 2016 is due to be published in November 2017.

The largest overarching expenditure groups comprised substance misuse, which averaged around 28% of the total budget over the three years; spend on sexual health services (23%); and the miscellaneous categories (22%). Excluding spend on substance misuse for children and young people, spend on people aged 19 and under represented 13% of the budget in 2013 and 2014, but this rose to 28% in 2015 when local authorities became responsible for under 5s.

Graphical comparisons of planned and actual expenditure (£ billion) are shown in Figure 1. Some temporal patterns are clear: for example, spend on alcohol misuse in adults (yellow band) appears reasonably constant over the first three years, averaging £207m (planned spend: £204m). However, in 2016/17 the category was changed to ‘treatment for alcohol misuse’ (see Table 3), shown as the pale blue band in the bar on the far right hand side of the chart. Planned spend in 2016/17 on this category was lower at £183m, but it is not clear if this reflects the change in category definition, or is due to cuts in ‘core’ (excluding 0 to 5s) local authority budgets.

Figure 1: Categories of public health spend by LAs (£ bn): England, 2013-2016

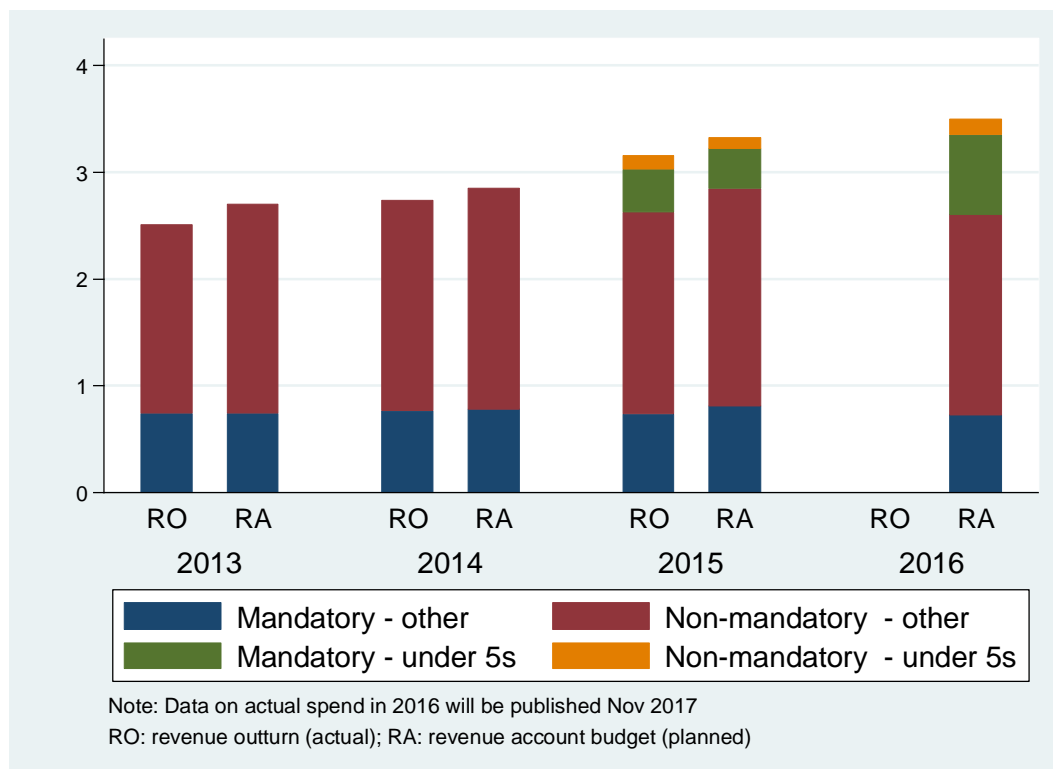


**Note:** SHS: sexual health services; NHS HC: NHS Health Check; NCMP: national child measurement programme; SM: substance misuse; PH: public health. Legend categories read down from left to right and correspond to the lowest to highest bands of the bars respectively on the graphs.

Figure 2 shows how total expenditure varied over time, distinguishing mandated (prescribed) and non-mandated (non-prescribed) expenditure. In 2015/16, local authorities received additional funds to commission public health services for children aged 0 to 5. These are shown separately as green / orange bars in Figure 2. Local authority budgets were increased to reflect these additional responsibilities for under 5s. However, the King’s Fund notes that if these additional funds are removed, so that budgets are compared on a like-for-like basis, public health budgets have fallen by 4% since 2013/14. This reflects both a £200m in-year cut (2015/16) and further annual cuts of 3.9% over the period 2016/17 to 2020/21 ([King’s Fund, 2017](#)).

In our two national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) the percentage of respondents who considered that the budget provided useful data for comparison rose from 51% in 2015 to 64% in 2016. However, in both years just 36% believed the budget returns provided an accurate picture of public health spending across a local authority, possibly reflecting the fact that ring-fenced budgets were commonly used for public health activities across local authority directorates (9 in 10 respondents).

Figure 2: Trends in planned and actual public health expenditure by LAs: England, 2013-2016



### 6.1.3 Key themes

Five key themes emerged from the study:

1. the impact of cuts to the public health budget;
2. the benefits and disbenefits of the ring fence;
3. the value of distinguishing between mandated and non-mandated services;
4. scrutiny and governance arrangements in relation to the budget;
5. changes over time in the pattern of deployment across the budget categories and, more widely, across directorates.

#### **Theme 1: The impact of cuts to the public health budget**

Case study sites which had started from a relatively low level of public health funding, as reflected in previous public health spend by the former PCTs, had benefited from an increase in the public health budget since the reforms. However, all sites were impacted by subsequent reductions in the budget (from 2015) notably the unexpected in-year cuts to the public health budget in 2015, which were viewed as disruptive and damaging, given existing contractual responsibilities. Delays in confirming allocations had also led to contractual difficulties with providers. One DPH noted:

*The gap was having lost £1.4m with almost no notice, and we actually found out about how much money we were going to get for 2016/17 on the day of the council meeting in February.*

Changes in the target allocation formula for the public health budget for 2016/17 meant that funding for some sites had been further reduced and a CE noted that 'it clearly directs resources away from greatest need, which is almost perverse in terms of the central thrust of public health investment to target inequality...'. Reductions were most marked in areas which had benefited from high levels of spending on preventive services by the former PCTs, although damage was less where there were public health budget reserves on which to draw.

In a site where a comparatively low sum had been transferred following the reforms, the DPH described the budget as 20% below its target, despite the authority receiving maximum growth, and argued that 'absolutely no account of need' had been taken in relation to the in-year grant cuts and further planned cuts. This interviewee commented:

*So in an area which has got major public health needs and the pressures of population growth and an influx of a diverse population, genuinely short of money, the centre has taken absolutely no notice and has cut {name of site} the same as it's cut everywhere else.*

In this case, the local authority had compensated for the cut to the public health budget by drawing on funding from other directorates 'because they can absolutely see those needs'. While loans were also sometimes provided, in other cases, cuts were to be absorbed within the ring-fenced budget with public health required to 'consume its own smoke'. Common to all sites, as in the first phase, was a process of re-commissioning services as contracts came to an end, focusing on efficiencies and more detailed specifications.

Interviewees reported different ways of responding to the common challenges of austerity - from 'salami slicing' to using the total resource of the authority to encourage return on investment and manage demand for social care.

In second phase fieldwork, interviewees across most sites commented on budget cuts, savings required and disinvestment choices that now had to be made. These included: both reducing and targeting lifestyle services; negotiating for reductions in existing contracts; prioritising strategic development through public health teams rather than their commissioning role; prioritising different public health services (or stopping some services altogether); assessing cost-effectiveness (or simply aiming for 'harm reduction'); and continued 're-badging of services'.

As one example, a DPH noted:

*We will, by the time we get to the end of this financial year, we will have taken probably about £3½m out of lifestyle interventions as our chosen area of disinvestment compared to other areas of service that we might disinvest from.*

Services cited as having been reduced included sexual health services, weight management, smoking cessation, sports and leisure, and the 'wider preventative offer'. In one site, it was anticipated that 'there are lots of things that won't be funded in the future; particularly around obesity, health trainers, physical activity, suicide prevention, as some examples'. As funding became tighter, choices became starker. In one site, an Executive Director considered that, in the case of drug treatment for example, this could lead to prioritising treatment for parents, given the impact on their children and longer-term health outcomes. Interviewees in some sites noted that services such as weight management and FNPs had been discontinued (the latter as part of reorganisation of services for 0-5s). There were different emphases across sites, however, and one DPH commented that the decision had been taken to prioritise weight management over smoking cessation services.

In one site with a low historical allocation, the ring-fenced reserve had been ‘demolished’ by the cuts. This had led to withdrawal of funding for districts for public health services, cuts in obesity services, no further grants to the VCSE sector and little room for manoeuvre elsewhere, with a cessation of ‘sideways spend’ in other areas. Following an equity impact assessment of all services, it had also resulted in the (temporary) suspension of the universal NHS health checks programme in primary care (although targeted health checks for disadvantaged groups continued).

Interviewees in both first and second phase fieldwork noted that commissioning specific preventive services, including CVD risk management and smoking cessation services could usefully revert to the NHS as part of the whole patient pathway, as could some treatment services which were not considered to fit well into local government. Otherwise, the budget could continue to be eroded and there would be further fragmentation with primary care preventive services.

All sites focused on targeting scarce resources (see also 6.2.4). For smoking cessation services, for example, this meant ‘spending more of the budget on higher risk, highly dependent, more vulnerable smokers, and spending less on smoking cessation for other smokers who don’t fall into that category’. However, some second phase interviewees had become less concerned about the decline in lifestyle services, arguing that the evidence base was not robust (with childhood obesity cited as an example), and they provided a poor return on investment, as expressed by one DPH:

*Because lifestyle services are a blunt tool - they’re relatively costly as an intervention. They suffer all of the same inverse access problems as other public services do. They are a relatively low unit of effectiveness by and large in terms of the actual gain they create at a population level.*

In another site, the DPH considered commissioning traditional lifestyle services was of less importance than developing the strategic influence of public health teams. He noted:

*By spending less money on weight management, on lifestyle interventions, and spending more of our time and energy on looking at the environment and the system and policy, it is starting to feel like we’re making a bit of progress. But obviously it’s going to take years.*

As in the first phase, the ‘totality of the resource’, and how to maximise its public health impact was emphasised, rather than the ring-fenced budget *per se*. One DPH commented:

*We’ve made efficiencies in some areas, some of our big contract areas, but we’ve reinvested that saving into other areas of public health activity. Some of it rescuing preventive interventions in other directorates from being cut by central government as a result of the 40% cuts to local authorities.*

National surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) also explored the impact of cuts to the budget. More respondents in 2016 than in 2015 considered that top-slicing had occurred (47% compared with 39%). When commenting on the question of top-slicing (n=20 across both surveys), reasons included covering local authority overheads and corporate costs and contributing to council saving targets and to cross-council work. In one case, a DPH (Survey 1) commented that almost a third of the public health budget had been diverted to ‘in-house occupational health service, adult social care re-ablement services, adult social care placements and a whole host of corporate recharges’. Those who felt that top-slicing had occurred apportioned responsibility to central government for imposing cuts on local government and public health budgets. Some referred to using reserves to protect spending levels, and others spoke positively of funding for public health activities being generated through support from within other directorates.



## **Theme 2: Views of the ring fence**

While the point was made that public health spend had been neither ring-fenced nor protected in the NHS, this was viewed by some first phase interviewees as a further argument for holding on to the protection now afforded by a ring-fenced budget. Some local authorities were described as fully respecting the rules around the ring fence, despite the financial context. One interviewee commented:

*I think having clear responsibility for public health supported by a funding source, the public health grant, and clarity about what programmes are funded through that route. I think that has helped to keep a focus on public health maintained as a priority.*

In another site, the DPH argued that most of the initiatives carried out to meet local health needs had been possible 'because we've had the money protected to do it' and another noted the benefits of delegated authority and control over the budget for ensuring its allocation in a way that was consistent with public health objectives.

Interviewees put forward various supporting arguments. For example, Elected Members might not prioritise public health, and the time lag between interventions and outcomes in public health meant that spend could be withdrawn before there was time to demonstrate improved outcomes (often cited as the key driver of local authority commissioning decisions). Also, it was considered to protect spending on universal services, which some perceived as less of a priority in local authorities. The main reason for retaining the ring fence, however, was the financial situation of local authorities, expressed by one CCG interviewee as follows:

*The problem is if it was removed, given the fact that the local authorities like this one losing the most from their budget, well what would you do if you were the leader of the council? And you were faced with some difficult choices between spending on social care, adult social care, education ... what would you choose to preserve and to cut?*

The fact remained that it was a small proportion of the local authority budget and a strategic approach to prevention across a local authority required far greater investment than that represented by the public health budget. For this reason, some interviewees did not consider it as an important focus for attention. Moreover, the ring fence did not prove a barrier in practice, as services could be reclassified to align with budget reporting and there were few checks and balances compared with other local authority functions, such as adult social care and education. It was more of a 'chain link' fence, as one DPH put it. An Elected Member expressed this as follows:

*£x million in our ring fence. That's grown now with the health visiting coming over. But what the council spends on public health related activity far far exceeds that sum. So you could very easily, and we didn't but if you'd wished to, you could very easily have thinned all of those contracts right off the bat, and badged x million worth of existing spending against public health activity, if you'd wanted to. And that isn't what we've done but, so in that sense the ring fence, I've never felt was particularly meaningful.*

While most interviewees favoured the ring fence, there were divergent views by role. In general, most (but not all) executive and service directors considered it unhelpful while most DsPH, NHSE, CCG, VCSE sector and Healthwatch interviewees were in favour. Unlike senior managers, many Elected Members also favoured its retention. Both national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), showed a majority (59% (2015) and 64% (2016) in favour of retaining the ring fence.

While the main argument against the ring fence was the importance of the totality of the resource for public health, there were also risks of the ring fence becoming an 'artificial barrier' against other funding streams, promoting an 'us and them' mentality and implying that every other local authority activity was unrelated to public health. It reduced flexibility, local discretion and the ability to align services to local needs and it was not clear why it should enjoy a privileged status at a time when cuts were being made across local authority services. Furthermore, it could be interpreted as signifying a lack of trust in the decision-making and priority-setting processes in local authorities. Instead, it was argued, the focus should be on outcomes and on integrating activities across the local authority which promoted wellbeing rather than on specific budgets and services.

Disquiet over the ring-fenced status accorded to the public health budget was intensified by the extent of cuts being implemented elsewhere. This was described as 'two different worlds'. A CE commented:

*We've got social care people managing operations, trying to reduce the costs of everything and then public health people doing things that the social care people are thinking 'why are they doing this?' .... And it {public health} tended to come in to work alongside social care and the people they're working alongside were doing major cuts.*

Some interviewees who were against the ring fence in principle nevertheless described it as useful in transition, as an 'awareness raising tool' and helping to 'identify the public health outcomes that you're achieving against the ring-fenced budget'. It was argued that the ring fence allowed time for Elected Members to fully understand and take on their new public health responsibilities.

For sites with an alignment of values, a strong public health ethos across the local authority, and a preventive focus across directorates, the maintenance of the ring fence was seen as less important and funds were less likely to be used for other purposes. A service director noted:

*So I think if you've got that strategic alignment and you've got political leadership and officer level leadership that is wired up in that way and understands that you need to invest in early intervention and prevention to make an impact longer term, it's not a concern.*

Second phase interviewees expressed more reservations over the extent to which the ring fence protected anything in practice and dangers of being seen as 'outside' the council. The ring fence could also promote the (unfounded) view that it was adequate for providing public health services. Also more evident in second phase interviews was the importance of room for manoeuvre which a requirement to account for spend in each of the budget categories could work against. Nevertheless, providing mandated services without the protection of a ring fence would be difficult. It was unclear how accountability for delivering public health services would be achieved if spending was no longer reported against the budget categories. One DPH noted:

*So nationwide I think there is a case for the ring-fence staying on. Simply because we don't have an Ofsted and we don't have a lot of legislation, so what else do you have when push comes to shove?*

Changes between first and second phase fieldwork were echoed in a comparison of the two national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), with an increase in the percentage of respondents agreeing that the ring-fenced budget protected public health services (from 59% to 67%). Comments from both surveys showed scepticism over the extent to which the ring fence offered protection or provided an accurate picture of public health spend - of the 13 respondents (Survey 1) who commented on whether *the public health budget provided an accurate*

*picture of public health spend*, none considered it did so. One DPH respondent noted that the 'boundary between ring-fenced services and other mainstream council services is getting progressively weaker' and another that 'creative "rebadging" means that the links between spend and public health outcomes are tenuous in some cases'. Different views were expressed over whether *the public health budget should be retained in its present form*, including its importance in protecting services in transition (but with a need for better auditing) and the need for it to be 'blended into the local government core grant' over time.

### **Theme 3: Mandated and non-mandated services**

Many interviewees were unclear over which services were mandated or questioned their relevance given local population needs and the importance of focusing on outcomes rather than inputs. There was also some disagreement over what should be considered as a mandated service, with the suggestion of alternative/additional services – or even that all public health services should be mandated. Where there was a relatively small public health budget, mandated services could take up a large proportion and a DPH in a site where this applied argued that a 'free rein' was needed and that mandatory elements should be discarded. There was a view among some CCG interviewees that more value could be gained from smoking cessation services (non-mandated) than from NHS Health Checks (mandated) and that some of the mandatory requirements did not have a robust evidence base. Services related to substance abuse, alcohol and smoking were cited as more important than the mandated NCMP. If the ring fence were to be discontinued, some interviewees considered that the list of mandated services should be refreshed in order to protect services. One DPH commented:

*But if we don't have a ring fence and we don't have mandatory, I would fear for public health services, I think, generally.*

A broader issue was the primacy of local authority statutory duties and the relative status of the public health mandated services which were less clearly specified and mandated rather than statutory. As a result of potential risks to preventive services transferred from the NHS, one interviewee commented:

*So it depends on whether the pendulum's swung too far, or whether you should actually take some of the professional public health and give it back to the health service, because it's almost meaningless to the local authority.*

In second phase fieldwork, as mentioned above, there was less emphasis on lifestyle services and more criticism of a lack of minimum requirements for mandated services. There were further suggestions that treatment services should be returned to the NHS.

Comparing the surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), there was a slight increase (from 33% to 42%) in the percentage of respondents favouring retention of the distinction between mandated and non-mandated services – although they remained in the minority. Most of those who commented on this topic (n=13 (2015) and 16 (2016)) were critical of the notion of mandated services: they were considered inconsistent, arbitrary, 'artificial', not the 'right choice' of services, and not reflective of the evidence base or of services of greatest importance. A DPH respondent commented:

*The list of mandated services is not particularly helpful as it is not determined by any specific prioritisation process. Smoking cessation for example, is not a mandated service but would rate as one of the most cost-effective public health interventions available.*

There was also concern that mandated services would become the only focus for public health spending. Moreover, mandated services (such as Health Checks and the NCMP) were described as about 'measurement rather than action'. One DPH respondent, reflecting interviewee views, commented that the meaning of 'mandated' was not clear:

*It would also be useful to understand the what "Mandated" means - this is not the equivalent of "statutory" so what will happen if we do not implement mandated programmes?*

#### **Theme 4: How and where the budget is discussed and scrutinised**

Discussion of the public health budget followed usual local authority procedures for budget agreement and scrutiny. Scrutiny was achieved through the chairing role of Elected Members on specific committees, through a range of Scrutiny Committees, regular financial monitoring arrangements, and through the Cabinet and the full council. The public health budget would, therefore, form part of these formal reporting arrangements, although the point was made that while the money was scrutinised, including when moved into different directorates, the costs and benefits of such changes were not necessarily scrutinised. Although there were examples of interest in the public health budget, particularly in the early transition phase, some interviewees criticised the extent to which the public health budget was formally scrutinised - less rigorously, it was argued, than scrutiny by local authorities of the NHS budget, for example.

Returns for the reporting categories of the public health budget were processed through finance departments, although it was noted that for some reporting categories, such as health protection, the input was difficult to describe or cost. A further complexity was that reporting categories did not reflect the balance of public health-related spend across the local authority, although some categories, such as smoking cessation, were relatively straightforward. Interviewees were unable to shed much light on the 'Miscellaneous' reporting category, although one thought it reflected spend on wider determinants of health and another that it had been dispensed with in that authority, as all spending was subsumed under other categories.

There was little discussion of the budget in HWBs and little detailed knowledge of the budget among HWB members (other than the DPH) or of how much was spent in each of the reporting categories. A VCSE sector interviewee commented:

*I don't really know what the budget is. And I don't believe that all the members of the health and wellbeing board know what the budget is, and there hasn't been to date a presentation on the public health budget, so I don't know what it is. What I see is sort of projects and initiatives that come to the board for approval, and an example of that might be the Better Care Fund.*

HWB discussions were described as largely focused on strategic direction or individual proposals for commissioning (or, more commonly, decommissioning). Debates over how to prioritise across the public health budget as a whole were unusual, although exercises of this kind had been carried out in three sites as part of a decommissioning process. A HWB Chair noted:

*The director of public health brings forward his proposals as to where he wants to increase spending, decrease spending, bring in greater efficiencies, find new ways of combining services.*

In most sites, detailed discussion took place in executive groups and proposals were presented to the HWB for approval. This was not considered surprising by most interviewees, and was consistent with views that HWBs were not decision-making bodies, did not fit neatly into a local authority

structure and were sometimes described as ‘talking shops’, or ‘tick box’ exercises (see sub-section 6.4.3). In second phase interviews too, there was scepticism over the capacity of HWBs to set priorities, with one interviewee commenting that ‘I don’t think it is that brave or that well-informed to have those discussions’.

In two sites, the public health budget had been subject to more detailed discussions in the HWB. Some interviewees assumed that scrutiny of the public health budget was the role of the HWB, raising questions over links across Scrutiny Committees and HWBs or whether reports of Scrutiny Committees were considered by HWBs. The breadth of public health (and dispersal of the public health budget and public health staff) meant a wide range of Scrutiny (or Select) Committees could potentially be involved.

Interviewees argued that the reforms had served to question definitions of public health commissioning and how it should be prioritised in a local authority context. Reported influences on commissioning included: assessments of return on investment; views on individual responsibility; a shift towards demand management and secondary prevention; and views over the evidence base. For example, there were differences between local authorities and the NHS in how cost-effectiveness was considered. While smoking cessation services were considered a cost-effective use of resources in the NHS, as assessed through Quality Adjusted Life Years (QALYs), the same arguments did not apply to the same extent for local authority services, such as social care or children’s services where the value of timely social intervention could be substantial and accrue over a lifetime. One CE noted:

*We know, for example, that if we can turn around the life of a 21 year old, then between the age of 21 and 70 if that man is in and out of prison, on housing benefit, usually has an average of 2.3 children etc. etc., costs the state just over a million pounds up to the age of 70. If we can actually change that life around the net added value is about a million pounds. ... But that takes, you know, that’s a 50 year trial, so you can’t evaluate it.*

Nevertheless, it was argued that the business case for transferring public health funds into other directorates and for other purposes had not been adequately explored and a more rigorous assessment of costs and benefits was required. One DPH described a ‘belated’ attempt to do this, having been ‘mugged’. The point was also made that local authorities often focused on where costs could be reduced in staff, services and the estate, rather than effects across a wider system.

This section raises questions of local variation in spend in relation to public health outcomes and how this is monitored in a local authority context.

#### ***Theme 5: How the public health budget was deployed***

As a general rule, directly commissioned services for sexual health, drugs and alcohol accounted for the bulk of the ring-fenced budget and the greatest initial influence in the post-transition phase was historical spend, given inherited contractual obligations. The proportion of spend across the categories had not changed substantially between first and second phase interviews according to most interviewees. However, surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) suggest that there was increased reallocation of funds across the budget categories (81% of respondents in 2016 compared with 64% in 2015), although numbers are small.

Once contracts expired, services were being re-commissioned, demonstrating differences from the NHS in commissioning processes, choice of providers and in service specifications (described further in sub-section 6.2.2). In one of the multi-district authorities, some of the public health budget was devolved to districts.

However, the public health budget was subject to a spectrum of influences and demands. At one end of the spectrum were examples of a 'purist' approach to the ring-fenced budget, with strategic development under DPH control, with delegated authority (whether located in a separate directorate or not) and with the budget largely protected. Three sites reported arrangements along these lines in first phase interviews. In other sites, other directorates managed part (or most) of the budget.

At the other end of the spectrum was the view that the public health budget was a local authority budget and subject to local authority priorities and statutory responsibilities, including the obligation to live within its resources. Therefore, the public health budget had to align with local authority priorities and commissioning intentions. A service director commented:

*How do we make sure that the public health budget fits in with that overall commissioning intention of the council, which is to do what we can to prevent children from being harmed, to prevent adults being vulnerable and lonely and all of that... and citizens feeling safe.*

However, this was not an 'either-or' situation, as there were many alignments across public health priorities and existing services, including children's wellbeing and policies to reduce drugs and alcohol. Much activity was directed towards preventing admission to statutory services, reflecting the priority for all authorities to reduce the costs of health and social care.

In some sites (and in recognition of the fact that public health activities were already being carried out within local authority directorates), accountability and monitoring arrangements were in place, or planned, in relation to how the public health budget was being spent across directorates. Service delivery agreements specifying activities and outcomes were being developed in order to avoid loss of management control of the budget. This was described as useful for public health, for providing an audit trail for PHE and for identifying as a 'public health person' those staff in other directorates who were funded through the public health grant, professionally accountable to the DPH and who needed to continue their professional development. The same processes could be applied to funds from other directorates, if transferred to public health.

In one case, a mapping exercise had been carried out early in the transfer to identify aligned public health activity across the authority, followed by a prioritisation framework, based on Marmot principles, to help determine where the public health budget should be aligned. This was associated with public health delivery agreements with the directorates, which 'helped develop the role of the whole council in delivering public health indicators'.

One site had gone further, establishing a public health investment plan where use of the public health grant was contingent on matched funds from directorates for spending on public health-related outcomes. The use of the public health budget as a catalyst for embedding public health across local authority directorates is further discussed in sub-section 6.4.3.

Realignment was often associated with reduction or decommissioning of original public health programmes (such as substance abuse or weight management) and there was recognition in some sites that the use and reporting of the budget was 'imaginative' or 'rebadged' with 'osmosis across the ring fence'. One CE commented that 'a lot of the things that we would normally do we have reclassified, I think legitimately, as public health activity' and in another site, an Elected Member commented that:

*we have used some of the money to basically protect some other cuts that were going to take place in the organisation around things that have a health input... public health is less*

*safe funding-wise with the local authority than it is in the health service, because of the scale of our cuts.*

This was particularly the case for parks and leisure or housing initiatives, which could be included under 'wider determinants of health'. In one site, it was mentioned that efficiency savings from preventive services would not be invested into additional preventive services but into addressing wider determinants of health, which were an important part of the authority's role in promoting public health.

In most sites, however, interviewees reported a wide range of ways in which the budget had been deployed over and above budget categories. Box 3 brings together examples from interviewees and survey respondents. (There were 31 comments across both surveys.)

**Box 3: How the budget was deployed, 'rebadged' and 'realigned'**

- The public health budget was often used to support children's services, children's centres and managed by the relevant directorates:
- Also may support a wide range of local authority services and responsibilities, including road safety, sports and leisure; park rangers, green spaces, promoting access to countryside, worklessness, early intervention to prevent homelessness, safeguarding, rehabilitation and re-ablement services, carers' support, adult education, domestic abuse, care and repair through housing, Healthwatch;
- Support for self-care in order to reduce demands on adult social care and in line with the prevention requirements of the Care Act;
- Supporting People: providing funding for supported housing for people with substance misuse problems (aligned with substance misuse services);
- Voluntary sector grants, including pump-priming the voluntary sector to promote discharge from hospital, befriending and help-at-home services, winter warmth through Age UK, training volunteers for Age UK, neighbourhood-based voluntary sector organisation for older people;
- Working with schools with children with emotional difficulties (one example was commissioned through the public health team with matched funding from the direct schools grant);
- Using the budget as a catalyst to promote public health outcomes across directorates. This could involve replacing core funding with public health funding and influencing service delivery, developing projects for subsequent co-investment (e.g. for fuel poverty) and/or national investment;
- Using the budget to redesign the public health workforce, through skills escalator and CPD programmes;
- Contribution to neighbourhood networks (e.g. neighbourhood-based VCSE networks for tackling isolation and loneliness);
- Public health staff carrying out elements of others' work due to staff reductions;
- Contributions to overall saving requirements for the local authority;
- Contributions to corporate services to reflect support for the public health team;
- Pump-priming for primary care for identification of atrial fibrillation;
- New public mental health service;
- Health of the local authority workforce.

However, a survey respondent - a DPH - pointed out that staff input, rather than the budget, often led to change, commenting that:

*It is the work of specific public health workers and officers across the council that has achieved this rather than the grant (except insofar as it protects core public health teams).*

Second phase interviewees increasingly emphasised: the inseparability of public health from other local authority activities; the shifts from lifestyle services to strategic development; and the alignment of the grant with council priorities. In relation to the latter, there were examples of the grant being used for supported housing for priority groups and more generally, a shift to secondary prevention, preventing hospital admission and reducing demand for social care. A DPH commented:

*It's being used to support the funding of services like prevention and early intervention services that support people who are already in some difficulty, so secondary prevention services as opposed to primary prevention services.*

Moreover, the transfer of services for 0-5s from NHSE to local authorities, in October 2015, had led to more emphasis on integration of children's services. As one DPH put it: 'not just to have an integrated health offer, but an integrated children's services offer including health'.

There were examples of co-investment by CCGs in preventive services, such as for exercise on prescription, but also examples of funding healthcare public health through the grant, such as for pump-priming services in general practice to help identify patients with atrial fibrillation. In one site, however, the DPH emphasised the importance of focusing on primary prevention and considered secondary prevention as the responsibility of the NHS.

The surveys (n=39 (2015) and 36 (2016)) largely reflected changes in deployment of the budget, with a large majority of respondents considering the budget was used for public health activities across local authority directorates (87% in 2015 and 89% in 2016). Comments (n=10 (2015) and 11 (2016)) were largely positive, with one DPH commenting:

*We funded some parks and leisure expenditure and consider this to be an absolutely appropriate use of public health funding.*

The manifold uses of the budget, combined with variation in how local authorities categorise and code expenditure and the extent of local variation in needs and priorities reduce its value for comparative purposes. However, while weaknesses were recognised, one respondent observed that the data 'puts into perspective the massive differentials and inequalities in public health spend between areas within similar need'.

#### **6.1.4 Pooled arrangements**

Most pooling arrangements across CCGs and local authorities related historically to Section 75 arrangements (for services related to mental health, drugs and alcohol, children and vulnerable adults). Some sites had long-standing Section 75 agreements and, in one case, a history of the local authority managing substantial contracts on behalf of the CCG. More recently, pooling initiatives were related to the Better Care Fund, where a single pooled budget for health and social care encouraged joint working. A number of interviewees argued that the only route left for improving efficiency was to merge and make savings across the entire health and social care budget.

Budgets for prevention were often described as 'aligned', rather than pooled, and the extent of pooling arrangements was, to some extent, influenced by financial problems of the CCG, which had slowed progress in some areas. Box 4 includes examples of joint funding with CCGs for prevention. There were examples where pooling of CCG funds, adult social care funds and public health funds related to adults (which were currently aligned) were under discussion.



#### Box 4: Joint funding across CCGs and local authorities highlighted by interviewees and survey respondents

- Pooled budget for health checks;
- Pooled funding for children's services across the CCG, local authority and NHSE;
- CCG funding for services to promote emotional health and wellbeing in schools;
- Tender with one specification for children's services, pooling all funding around health visiting, school nursing, children's centres, the healthy child programme, and developing a joint procurement across the CCG, including the community nursing services and Child and Adolescent Mental Health Services (CAMHS) (aligned rather than pooled funding);
- Pooled funding for CAMHS and CCG investment in schools to promote emotional health and wellbeing;
- Joint commissioning of integrated lifestyle services, where resources were available from the CCG (for level 3 weight management services), the Better Care Fund (on the preventive side) and the public health grant. This involved bringing together a range of fragmented services under a new model and with an integrated service provider;
- Health and wellbeing hubs (based in districts) funded through the public health grant, CCG and police and crime commissioner (open access or through GP referral) providing healthy lifestyle services as well as social prescribing;
- Children and Young People community services through joint commissioning (includes CAMHS, CCG community health services and some council preventive services);
- A and E alcohol interventions;
- CCG funding for early intervention for alcohol initiatives;
- Co-investment by CCG in leisure services and in exercise on prescription;
- Community advice hubs led by the voluntary sector, located in libraries, alongside wellbeing hubs;
- Co-investment in drugs and alcohol services;
- Prescription of nicotine replacement therapy;
- 'Community connectors', funded through a joint commissioning board for lifestyle services and also connecting to wider support services and social prescribing;
- Joint staffing arrangements;
- Services for homeless people;
- VCS support for children (0-3).

Plans were discussed in integrated commissioning groups/boards (also involving public health staff) and relevant partners contributed to initiatives such as integrated neighbourhood teams/hubs. These hubs were largely focused on frailty, early intervention and prevention of hospital admission, targeted to those most at risk of admission, and described by one interviewee as 'one front door' for health, wellbeing and social care services. While prevention (and wellbeing) in this context often referred to prevention of hospital admission, combined with developing 'community capacity', interviewees commented on the scope for expanding the preventive potential of such networks, although the extent to which this had been realised was difficult to assess.

One site noted the development of an 'integrated wellness organisation', a multi-specialty community provider which combined treatment, early intervention and prevention in one locality 'wrapped around GP services' and including mental health services. Another site explicitly linked this integrated neighbourhood approach with packages of support including preventive services for those identified through GP practices as at risk of avoidable hospital admission, in this case, as explained by the CE, 'quite often people aged 25 to 49 with low level mental health issues, alcohol, all sorts of other things going on'.

Both national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) confirmed that pooling of funds across CCGs and local authorities was uncommon. When asked about budgetary categories where pooling had occurred, responses in 2015 ranged from 3% (for contraception and also for nutrition) to 24% (alcohol misuse in adults). There was some indication of increased pooling in 2016 across 12 areas, although numbers are too small to report.

Table 5 brings together survey findings for 2015 and 2016 for three questions related to use of the public health budget by reporting categories: whether funding was adequate; whether funding was pooled with the CCG; and whether there was funding from more than one directorate.

**Table 5: Public health budget: survey results, 2015 and 2016**

	Was RF budget adequate? (% Agree)		Were funds pooled with CCG? (% Yes)		Funding from >1 local authority directorate? (% Yes)	
	2015	2016	2015	2016	2015	2016
Obesity (adults)	19	26	13.3	15	17	15
Obesity (children)	19	29	7.1	15	24	20
NCMP	81	79		7	4	4
Exercise (adults)	28	29	16.7	15	39	40
Exercise (children)	19	23	6.9	15	35	32
NHS health check	69	69	7.1	7	11	
STI testing and treatment	62	71	6.9	12	4	4
Contraception	65	69	3.4	16	7	12
SHS (advice prevention promotion)	57	68	7.1	12	10	20
Drug misuse (adults)	68	63	15.6	21	33	19
Alcohol misuse (adults)	38	40	24.2	17	36	19
Drug and alcohol misuse (young people)	35	37	18.8	21	39	22
Stop smoking services and interventions	70	53	9.4	15	7	12
Wider tobacco control	46	40	10.0	19	33	33
Children 5-19 public health programmes	38	56	9.4	4	32	23
Nutrition	39	32	3.2	4	11	20
Weight management services	28	37	9.7	12	10	8
Prevention of excess winter deaths	26	34	23.3	19	55	38

**Note:** Response rates for the surveys were low and this prevents generalisation of results. For survey one, there were 39 responses (11 CCG members of HWBs (response rate: 7.2%, 11/152) and 28 DsPH (20.7%, 28/135)). For survey 2, there were 36 responses including 6 CCG members of HWBs (response rate 4%, 6/152) and 30 DsPH/ other public health representatives (response rate 23%, 30/133)).

Results are similar across both surveys in relation to the adequacy of funding for public health services. Areas where funding was least likely to be considered adequate were alcohol misuse, obesity and exercise (for both adults and children). This contrasted with the mandatory functions of the NCMP and NHS Health Checks. In addition, while over 70% of respondents considered funding for stop smoking services was adequate in 2015, this had dropped to 53% in 2016.

In relation to funding from more than one directorate, responses were similar across both surveys, with the exception of increases in the percentage of respondents identifying funding from more than one directorate for sexual health services and nutrition in 2016, and decreases in those identifying alcohol misuse (adults), drug and alcohol misuse (young people) and prevention of excess winter deaths. Around a third of respondents reported funding from more than one directorate for exercise schemes (for adults and children) and wider tobacco control.

### **6.1.5 Conclusions**

This section raises questions over minimum levels of provision for specified public health services, the balance to be achieved across whole system and traditional lifestyle approaches, and debates over how the budget could best be used across the local authority to maximise benefit and meet priority needs. It underlines the lack of protection for preventive services, as reflected in the public health budget reporting categories, including those classified as mandated services, the extent of local variation in spend in relation to public health outcomes and in how this is monitored in a local authority context.

It illustrates broader themes of how public health is being defined and prioritised across the local authority, the relative importance attached to traditional public health services and the level of control of DsPH over the budget. It also demonstrates the extent to which the current financial situation influences options available to local authorities in the sphere of public health.

## **6.2 Towards a new culture of commissioning**

### **6.2.1 Introduction**

The second workstream of the study explores how preventive services are being commissioned and provided in a new organisational and governance context. It includes changes in providers, the extent to which communities are being involved, co-design initiatives and overall impact on uptake and outcomes. NHS Health Checks and childhood obesity were the subject of more detailed study, including the impact of spend on outcomes, and are discussed in more detail in sub-section 6.3.

The reforms meant that not only were local authority commissioning arrangements applied to traditional preventive services but also that these services were increasingly being considered in the context of the commissioning priorities and wider strategic role of local authorities. Public health services were increasingly integrated and this took many forms, including: integrated lifestyle services; integration with services for children and adults; integration with a health and social care agenda; and more fundamentally, alignment and integration with local authority priorities and services. Changes in commissioning processes and in the nature of contracts (6.2.2) and new providers (6.2.3) are followed by a discussion of shifts in orientation towards local authority services (6.2.4) and local communities (6.2.5). This is followed by a review of how health inequalities are being conceptualised and addressed (6.2.6), changes in preventive services (6.2.7) and initiatives for community engagement and co-design (6.2.8). The shift in emphasis from problem-based commissioning to place-based community wellbeing is then discussed (6.2.9).

A key issue is the extent to which new commissioning responsibilities lead to innovative approaches which result in a greater impact on health and health inequalities than previously. The topic of innovation is discussed in more detail in sub-section 6.5 and RR 6.

### **6.2.2 Local authority commissioning processes**

There were differences in contractual processes between the NHS and local authorities and, in line with expectations of the reforms, shifts in preventive services towards social and community perspectives.

Interviewees perceived differences in how the NHS and local authorities commissioned preventive services, in particular for procurement processes, contract specification and in choice of providers. While outcomes-based commissioning was described as the direction of travel for both the NHS and local authorities, some NHSE and public health interviewees described local authority commissioning as being more narrowly focused on procurement and contracting processes, rather than on the phases of a commissioning cycle or on pathways of care.

In general, tendering processes were standardised and increasingly unified in a single commissioning facility for the local authority: the inclusion of public health commissioning into these centralised commissioning arrangements was established or being discussed in most sites in the first phase and was further extended by the second phase. As NHS contracts transferred to local authorities were re-commissioned, elements of a different 'culture of commissioning' became evident. It was noted that NHS contracts for preventive services had often been tied in to larger commissioning contracts, where the preventive element might not be the main focus, so re-commissioning had allowed for more 'public health-focused commissioning approaches'. In one site, it was argued that public health teams had closer contact with commissioning than had been the case in the NHS, as one interviewee noted:

*So, for example, they {public health} would now know how much of their spend is in the voluntary sector, how much is in health, how much is in local government, how much is invested internally. ... So yes, the model of commissioning has changed.*

The NHS system was described as 'technocratic', favouring certain providers, and 'laissez-faire' in its propensity to 'roll over' contracts rather than engage in new procurement exercises. Local authorities were constantly reviewing contracts and re-commissioning services, with a DPH commenting that: 'local government fundamentally does not like stasis in its service delivery'.

Interviewees across sites considered procurement in local authorities to be more disciplined and rigorous, less 'woolly' and more likely to focus on clear specifications and value for money in achieving successful outcomes, sometimes including a preventive element, and linked to incentives. This had resulted in efficiency savings as preventive services had been re-commissioned. Project management was described as robust, with less scope for the legal challenges commonly experienced in the NHS. It was argued by one DPH, for example, that the transfer of public health to local authorities had made public health teams more focused on 'outcomes evaluation and quality assurance'. Where services had been re-commissioned, most interviewees noted improved outcomes and there were examples of improved access, for example, for sexual health services. Formal scrutiny of businesses cases and market testing was described as a 'massive learning curve' for public health professionals, especially as they had not been responsible for the procurement elements of commissioning in the NHS. A DPH noted:

*And when I was in the NHS we'd never been able to get an integrated sexual health service, too much in-fighting. But actually coming to the council, going through proper re-commissioning, re-procurement process, we now have an integrated sexual health service.*

In the same site, re-commissioning drugs and alcohol services had led to greater emphasis on the impact on children and on domestic violence, making links across the authority's priorities in ways that encouraged innovation.

While some VCSE sector interviewees found the new commissioning arrangements supported VCSE engagement at the design or 'invitation to tender' stage, and supported small-grant funding for pilot

projects, others found local authority procurement processes 'labyrinthine'. One interviewee commented that:

*It feels like the procurement process almost initially means that public health feel they can't talk to people who might be supplying services because there's a brick wall and the procurement process forbids that.*

Others spoke of contract specifications which excluded small providers, leading to these organisations losing their core funding and effectively being left 'high and dry'.

Second phase interviewees reflected these changes in the process of re-commissioning once NHS contracts had expired: making efficiencies; clarifying specifications and performance against key outcomes; and re-commissioning in line with local priorities or to reflect changes in the evidence base. A DPH described how:

*what we've been able to do over the last three years is to make our commissioning and contracting process and our monitoring processes more sophisticated, so we can actually see what's happening in the most disadvantaged groups, as opposed to just a 'oh this is a service that we operate'.*

Second phase fieldwork also showed that commissioning preventive services was becoming increasingly integrated within specific directorates or formed part of a centralised commissioning facility, as described above.

### **6.2.3 Changes in the provider landscape**

The 'cosy' relationship between CCGs and NHS providers was described as being challenged, with more outsourcing and greater diversity of providers. The integration agenda was also seen as a route for new providers to emerge. In one site, there were new providers for all re-commissioned preventive services, with examples of changes from NHS providers to the VCSE or private sectors (or sometimes to 'accountable providers', acting in partnership). A CCG interviewee (Phase 1) commented as follows:

*So moving public health out of PCTs and putting it into a local authority has changed the culture of commissioning. So our local authority has tendered several services, and has awarded them to non-usual bodies, including the private sector. So that's been a shift, a different cultural shift and there's lots of learning from that so far. ... So yes that certainly opened my eyes to different options.*

By the time of second phase fieldwork, most sites had already re-commissioned major areas of spend in the public health budget, that is, sexual health services and drug and alcohol services, and had either completed or were in the process of re-commissioning healthy lifestyle services. Where services had been re-commissioned, most interviewees noted improved outcomes and there were examples of improved access, for example, for sexual health services. Interviewees also commented on shifts to 'in-house' services, for example, for leisure services (which could also provide services for other authorities) and for children's (0-19) services (although it was recognised that the latter required the development within the local authority of clinical governance systems for managed clinical services). In some sites, it was felt that the VCSE was effectively 'competing with the local authority to deliver, where they try to keep the resources in-house'.

In the national surveys of DPH and CCG members of HWBs, (n=39 (2015) and 36 (2016)) while only 25% (2016) considered that new healthy lifestyle services had been commissioned - a decline from

33% in 2015 - 80% considered lifestyle services had been reconfigured and 64% reported that new providers had been commissioned. As shown in Table 6, the first national survey showed that over one third of respondents indicated increased involvement in preventive services of local authority employees (44%), volunteers (44%), VCSE organisations (39%) and pharmacists (36%). The second survey shows remarkably little change overall, but with greatest increases for VCSE organisations (where a majority of respondents considered they were more involved in providing preventive services) and in community groups (from 28% in 2015 to 47% in 2016).

**Table 6: Changes in providers of preventive services**

Since the public health reforms are the following more or less involved in delivering preventive services in your local area?	% 'yes'	% 'yes'	Examples (74 comments)
	2015	2016	
Volunteers	44	42	Breast feeding support, weight management, peer support (substance misuse), integrated wellbeing
VCSE organisations	39	58	Smoking cessation, health trainers, sexual health, drug misuse, domestic abuse, public mental health, community engagement, care closer to home, older people, social prescribing
Health trainers and other peer support	21	33	Integrated wellbeing service. (Comments usually described a decline in services.)
Private providers	21	28	Sexual health services, integrated children's services, smoking cessation
Local Authority employees	44	47	Physical activity/leisure activities, mental health, healthy homes, Making Every Contact Count(MECC)
GP practices	13	14	Health promotion programme. (Comments generally described decreased involvement.)
Employer workplace schemes	31	31	Workplace charter accreditation, 'Better health at work' awards, workplace wellbeing schemes
Community groups	28	47	Community health champions, young health champions, local area partnerships
NHS Trusts	5	17	(Comments related to reductions.)
Pharmacists	36	36	Smoking cessation, health checks, sexual health services, flu vaccinations for care homes, public health awareness campaigns

**Note:** Response rates for the surveys were low and this prevents generalisation of results. For survey one, there were 39 responses (11 CCG members of HWBs (response rate: 7.2%, 11/152) and 28 DsPH (20.7%, 28/135)). For survey 2, there were 36 responses including 6 CCG members of HWBs (response rate 4%, 6/152) and 30 DsPH/ other public health representatives (response rate 23%, 30/133)).

A subsequent survey question asked for more detail on providers of services for smoking cessation, exercise, drug and alcohol misuse and weight management. This showed: a reported increase in 2016 in provision by the VCSE sector for all services except smoking cessation, with over 50% reporting VCSE providers (with the exception of smoking cessation and weight management services); in private sector providers (although reported by under 50% of respondents for all categories); and community groups, especially for healthy eating, alcohol misuse and exercise schemes. VCSE organisations were most often cited (by over 75%) as being involved in substance misuse services for adults. There was also increased involvement of volunteers, although numbers are small. While the use of health trainers was higher in 2016 than in 2015, this group was cited by a

majority for healthy eating and exercise schemes only, with local authority employees also prominent for the latter. NHS trusts were prominent for alcohol misuse and smoking cessation services: pharmacists were cited by 63% as being involved in smoking cessation services. There were declines across the board in preventive services from GP practices.

The survey of VCSE organisations involved in health promotion and prevention (survey 2 (RR3), n=39) showed relatively little involvement of the VCSE sector in health checks, smoking cessation, sexual health services and obesity-related services.

### ***Impact on the VCSE sector***

The survey of local Healthwatch and VCSE members of HWBs (survey 1 (RR3), n=34) showed that most respondents identified local authorities as the main commissioner of preventive services from the VCSE sector, followed by CCGs and joint funding across the local authority and CCG. Examples were cited of joint initiatives across the VCSE sector and statutory partners, national and local organisations within the sector, and across local VCSE organisations. The relevance of the VCSE sector to the Social Value Act's requirement for commissioners to secure added economic, social or environmental benefits for their local area was emphasised. Nevertheless, in response to the question of whether the public health reforms had an impact on a wide range of factors, including influence on commissioning, involvement in providing preventive services or emphasis on health inequalities, a majority of respondents indicated less emphasis/no change. None considered there was greater availability of funding and a third considered that complexity of contractual arrangements had increased.

It was argued that the VCSE sector could engage with groups reluctant to connect with statutory services, identify needs, raise awareness of health-related issues, establish community-based activities for vulnerable or isolated groups and could work with people in their own communities, sometimes in partnership with other services, such as youth offending teams. However, surveys and fieldwork illustrated a spectrum of engagement with the VCSE sector in providing and commissioning services. This was reflected by one respondent, whose organisation spanned two local authorities and who described a situation where 'we have excellent links with one, as do other agencies in the voluntary sector. With the other there is no apparent consultation or engagement and services are provided in-house.'

One survey respondent described active partnership and engagement across the VCSE sector, the local authority and the CCG, reflected in a wide range of projects, and another described close working with the Scrutiny Committee to identify needs of Black, Minority Ethnic and Refugee (BME) communities. One CCG had developed a separate strategy for VCSE sector engagement and another respondent described a competition-based approach to developing community initiatives, through a VCSE consortium. Examples included: providing a 'Winter Warmth' advice line, drawing on the expertise and networks of over 300 volunteers; providing an integrated advice service (health trainers, drug and alcohol advice and home adaptations); and a single referral route for preventive services provided through the VCSE sector.

Some authorities favoured larger 'block' contracts, including out-of-borough providers. Described as partly fuelled by cuts and the need for efficiencies in contracting, it was argued that this worked against innovation and the capacity of the local voluntary sector to engage: in one example, where multiple services had been offered as a single contract, 'only two organisations' were able to bid for them. Other sites favoured diverse contracts, wherever possible, with local VCSE providers, who had 'local knowledge and who are neighbourhood-based' and public health grants were used to support local community-based initiatives. Even for large tenders, however, there were examples of requirements to provide local apprenticeships.

However, not all changes were negative. One VCSE sector interviewee spoke of commissioning being 'more outward facing' since the public health reforms; another reported that spending cuts had been contained, and so there was no change in public health expenditure or on commissioning from the VCSE sector; and a third felt that the local authority was 'much more mindful of smaller organisations' than public health had been previously. Much, therefore, depended on the extent to which the VCSE sector was considered integral to local authority commissioning plans. The use of volunteers was increasing in some sites, and new health-related training opportunities for volunteers were being provided.

Respondents (n=34) to the survey of local Healthwatch and VCSE members of HWBs commented on changes needed if VCSE organisations and local Healthwatch were to exert greater influence on commissioning preventive services. These included: capacity and resources; greater recognition by commissioners; more emphasis on co-design and community involvement in priority development; and changes in the ways that HWBs reached decisions, with greater recognition of local Healthwatch and the VCSE sector. The survey of VCSE organisations involved in health promotion and prevention included detailed responses on the complexity of contractual arrangements; the need to include smaller VCSE groups; and of grounding commissioning priorities in community needs. Specific suggestions included reflecting the spirit of the Social Value Act in the commissioning process and for VCSE organisations to work more closely in partnership, providing evidence of effectiveness and impact. It was suggested that contracts included elements of active engagement and that plans for preventive services be signed off by local Healthwatch.

#### **6.2.4 Changing the orientation of preventive services**

Changes in the orientation of preventive services included: increased emphasis on social and community perspectives; targeting (whether as a direct result of cuts, in order to reduce demand or to address the needs of disadvantaged groups); and integration (of lifestyle services, preventive services within integrated health and social care services and with other local authority services). These are discussed in turn.

##### ***Towards social and community perspectives***

Interviewees highlighted a change of emphasis from the health or service outcomes favoured in the NHS to social outcomes, such as neighbourliness or reduced social disorder, combined with assessments of the social return on investment (SROI). Some interviewees welcomed the shift from the centralised performance management regime of the NHS to a focus on local needs and priorities. They described a combination of a greater preventive element in demand-led services and better links and synergies between preventive services and other local authority services, such as schools, leisure and housing. One of the tasks for public health teams was to 'add value' to a wide range of local authority services.

As services were re-commissioned, they could incorporate a social model, peer-based approaches to changing behaviour, social prescribing and greater emphasis on responding to community needs and experience. Services for children were increasingly considered in the context of the family and schools, for example. In one site, sexual health services had been re-commissioned with a more preventive focus and included voluntary sector input. In another site, where the weight management programme had previously been provided by an acute trust, was dietician-led and clinically-based, the specification for the new tender was described as 'a much more holistic, much more integrated model, much more based on behaviour change and psychosocial support'.

The survey of VCSE organisations involved in health promotion and prevention (survey 2 (RR3)) also reflected an emphasis on community engagement and integrated approaches to health and



wellbeing rather than on single interventions: advocacy, peer support, and volunteering were often combined. Of 62 preventive projects highlighted by respondents (n=39), many reflected holistic and integrated approaches, combining mental health and social wellbeing.

### **Targeting plus strategic action**

In some sites, re-commissioning had been based on equality impact assessments (as part of a budget-setting process) and had led to targeting and the 're-establishment of thresholds for access to services to people who are more likely to benefit'. Services were being redesigned to meet those with greatest need, through what were described as more sophisticated commissioning processes, including social marketing techniques, and increased monitoring. There was also evidence of less investment in lifestyle services but more emphasis on strategic development for better population effect (further discussed in section 6.4).

Second phase fieldwork demonstrated greater emphasis on targeting lifestyle services, such as smoking, to address needs of people from disadvantaged communities, those with mental health problems and 'intransigent' smokers. This was described as due to reductions in the budget and was reflected by a DPH who noted:

*I think we'll be spending more of the budget on higher risk, highly dependent, more vulnerable smokers, and spending less on smoking cessation for other smokers who don't fall into that category, primarily because more and more people are using e-cigarettes. But then spending more on tobacco control measures.*

Targeting could be combined with efforts by providers to encourage those with moderate need into universal services, such as leisure services which, in turn, could be encouraged to meet the needs of different groups. While targeting of services was usually associated with meeting needs of underserved groups, it was also described as a way of reducing costs, through identifying those making demands across a range of public services. A HWB Chair (Phase 2) commented:

*We've found things like, for instance, there's people who've presented at 20-odd different public sector providers over the last 12 months, had about 40 assessments and had no further action because they never trigger a criteria for any individual agency... if you actually started to look at them in a holistic way across the public sector, you can actually reduce demand and produce better outcomes for them.*

While targeting implied less emphasis on universal services or on proportionate universalism, it was often combined with wider strategic and policy action, for example, on tobacco control, which benefited a broader population. This was described by a DPH as 'taking the more whole system approach to changing the environment through policy, through legislation, through influence – which is starting to work and potentially could deliver far greater benefits than lifestyle change services.' These results were reflected in the surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), where 86% of respondents in 2016 reported that ways of encouraging healthy lifestyles were being considered across local authority directorates – an increase from 69% in 2015.

This reduction in traditional lifestyle services was increasingly accepted by interviewees in second phase fieldwork. A DPH noted:

*I am much more sanguine about the disinvestment in traditional commissioned services, and the reallocation of that resource to protect other parts of the council, other council services which will have an enormous short-term impact on health and wellbeing if they were cut. It feels I can live with that now.*

In another site, however, there were efforts to ensure ‘proportionate universalism’ was maintained and encouraged, not just in relation to public health services but across all council and NHS services. A DPH described this aim as being pursued through a ‘local mainstreaming of action for inequalities’, supported through advocacy, social engagement and social mobilisation, and working across ‘all the governance and political and professional networks in order to do so’.

For children’s services, different views emerged. In some sites, school services were also subject to targeting, although there were differences in the extent to which universal health visiting services were targeted, with one site emphasising the importance of maintaining universal coverage, with more targeted support available for children over five years old. FNPs had been widely decommissioned, with health visiting services and the early intervention programme sometimes strengthened in their place.

### ***Towards greater integration***

Integration was taking place across contracts for lifestyle services, with social care services and across local authority directorates. In addition, new contracts for substance abuse were integrating services for drugs and alcohol.

### ***Healthy lifestyle services***

The second national survey of DPH and CCG members of HWBs (2016) (n=36) showed that just over half of respondents reported that integrated wellbeing services were being provided. These could bring together under one contract a wide range of services previously provided separately, such as for exercise on prescription, nutrition, physical activity, smoking or weight management, developing pathways accordingly. In one site, for example, where GPs could refer to leisure services, wellbeing services or dieticians, there were plans to integrate services for obesity, healthy eating and physical activity.

While there were few examples of new healthy lifestyle initiatives being commissioned, case study sites had already re-commissioned and remodelled lifestyle services, or were in the process of doing so. In some sites, local health and wellbeing hubs were already well-established, sometimes partly CCG-funded. As discussed above, there was often an emphasis on social factors and a shift from ‘proximal clinical medical secondary prevention’ to interventions which recognised social conditions driving unhealthy lifestyles, that is, ‘risk conditions rather than just the risk factors’. This could be reflected in the role of community link workers described by a CCG interviewee as follows:

*So they might be able to go back into, say, their housing office to say 'can we sort out this neighbourhood issue'? They might be able to then come back into the employment office in terms of 'what training could be put around this'. They might be then getting to Citizen's Advice in terms of 'what's the debt management advice we can put around this'. And it gives a very different solution to what we would have done previously, which would have been 'here's some antidepressants, here's a sick note'.... It's allowed that much deeper understanding.*

These changes were combined with better use of council assets, such as leisure facilities, sometimes linked with social prescribing.

However, concerns over fragmentation of preventive services were voiced by some CCG and NHSE interviewees, for example, in relation to obesity, with less engagement with primary care preventive services prior to the reforms.

### *Integration across health and social care*

The integration agenda had led to collaboration, pooled budgets and locality or neighbourhood-based teams, hubs and networks, 'bringing public services closer at neighbourhood level'. As well as integrating community teams (primary care, social work, nursing and mental health), these could include police, housing and neighbourhood services. While the predominant focus was on supporting frail older people requiring health and social care, thereby reducing hospital admissions, there were examples where the preventive element of these neighbourhood systems was extended through broader locality-based 'wellness organisations', providing a single access point to a wide range of services and also considering wider determinants. Community hubs were a relatively new development, with different models for the hubs and the navigators/connectors/liaison workers connected to them, with different roles and levels of provision.

It was argued by some interviewees that preventive initiatives should be developed as part of wider programmes for integrating health and social care and form part of related local neighbourhood networks. Voluntary sector neighbourhood networks, trying to reduce social isolation, had been funded, in part, by the public health grant in some sites.

The point was made that true integration would lead to a greater focus on prevention across the whole system, from smoking cessation to wider determinants. As one DPH commented:

*Hopefully, we'll be coming back round again to putting all the money together and trying to maximise each pound to get the most health and wellbeing for every pound spent.*

In line with the integration agenda, the duty of prevention in the Care Act and the focus on transforming health and social care were local 'wellbeing services', designed to preserve independence. There was greater emphasis on secondary prevention, described as 'prevention of escalation of need, prevention of admission to higher cost interventions, whether that's social care or healthcare interventions'. A service director noted:

*And that has changed and it's added value to managing my front door, because, within a council, adult care is the reason why councils are about to go bust. So managing my front door for councils is far more important now than operating on a geologic timeframe, in their eyes. So there's been some reorientation of public health resources to better address my front door, combined with what I would have had in my own resource portfolio, to then achieve better effect.*

Public health teams were often considered as playing a key role in this area. A Director of Adult Social Services noted that:

*And so my, if you like, front door, wellbeing, preventative services, which manage how many people come through into adult social care, is managed by my public health colleagues.*

One HWB Chair considered that public health should be located within integrated health and social care arrangements, commenting that 'public health has more relevance in that social care and health arena than it does in the local authority arena as far as local authority work is concerned'. In the same vein, a commissioning lead from a different site noted that:

*The number of 85s is going up exponentially over the next 20 years, so actually, we've got to turn that around. How do we get into a prevent/reduce/delay kind of methodology? And I think public health's key to that.*

Second phase fieldwork showed further emphasis on secondary prevention, promoting independence and self-care, sometimes through a combination of statutory and non-statutory providers, regularly referred to as 'wellbeing' services. These could refer to lifestyle services as well as to services for those discharged from hospital or requiring support to remain independent (which could be funded through the public health budget). A HWB Chair described a wellbeing service as follows:

*We've got a voluntary group that are providing the service, we call it our wellbeing service, and this is for people who have just come out of hospital. It's our public health colleagues who have put in a contract for the six weeks out of hospital to ensure people recuperate.*

#### *Integration with local authority services and priorities*

The transfer of public health responsibilities allowed services to be commissioned in a different way, closer to council priorities and local communities and making better use of council assets, such as leisure services or children's centres. A DPH emphasised the importance of commissioning in a way 'that has really made stronger links to other priorities within the council'. More fundamentally, it shifted the focus, in the words of one DPH, away from 'public health commissioning' to 'commissioning for public health'. He emphasised that:

*It's not about the budget that we've brought from the NHS. It's about, what evidence-based things could we influence and direct, but that are the spend of the whole system, not just the public health department.*

This could be fostered through integration of public health teams within directorates for adult and children's services, reflecting a Marmot approach to promoting health across the life course. Improving children's readiness for school could influence a wide range of health and social inequalities and each element of the life course could incorporate preventive approaches. In one site, for example, a care leavers' team included a public health post, with the purpose of improving outcomes of care.

Integration with children's services was well developed: it allowed closer working of public health teams with children's centres and schools and encouraged preventive initiatives (such as regular running at school before lessons – extending from reception classes through to secondary schools, in one site). It could also promote coverage of immunisation and vaccination through involving children's centres and the social care workforce. It was also argued, for example, that the public health potential of school-based activities had been relatively neglected by public health teams prior to the reforms.

Following the transfer of services for 0-5s, services for 0-19s could be integrated, described in one site as drawing together '50 contracts', to be 'summarised and understood to see how we could bring all that together'. This would include all children's services, including CAMHS. In another site, re-design of health visiting and school nursing was described as shifting the emphasis from 'clinical and professional groupings to 'the child's perspective and the family's perspective', avoiding 'negotiating border points which are simply defined by professional roles'. Moreover, school nursing could be reframed to support the ongoing pastoral role of schools and provide targeted support to vulnerable groups, such as looked after children. It was argued, in this context, that there was increasing recognition of 'synergies between a council offer and a health offer at a universal level that could be much more powerful if it's integrated', that health impact, education impact and social care impact were connected, part of 'one conversation', and should routinely be considered in relation to commissioning children's services. This meant, for example, that interventions for

childhood obesity could be school-based and family-orientated. A Director of Children's Services noted:

*In my new world, I have three team managers, my early help, my social care and my health manager and they have a conversation. They have a conversation about how they best meet the needs of this child. They don't have a 'can I make a referral now?'... 'It doesn't reach our threshold'. They have a 'Please can all three of us sit down and have a conversation about this family? Who is best to provide the support? What does the support look like and how do we target our interventions?' It's a different conversation to the one that currently happens.*

However, there was also concern that prevention in a context of cuts and without some bridging finance would prove impossible to achieve and, in particular, that STPs (see sub-section 6.4.6) prioritised demand management of adult services which could lead to the neglect of children's services.

In most sites, there was some integration of public health staff and public health spending across local authority directorates, with a public health perspective provided through data analysis, health needs assessments and, in some cases, through integrating a preventive element into existing services. Responsibility for commissioning would lie with the relevant service director, who could also act as lead officer for the HWB, rather than the DPH. Second phase interviewees reinforced the importance of integration as fostering a more holistic and contextual approach across services.

### **6.2.5 Communities and community assets**

Interviewees across most sites emphasised the importance of context, looking at the needs of communities in their localities, encouraging communities to help themselves, and finding ways of building community capacity, including volunteer involvement (and training) and local neighbourhood networks. Often referred to as 'asset transfer', were opportunities for community groups to run local amenities, such as libraries and leisure centres.

The reforms had resulted in better linkages across preventive services and local communities. A DPH (Phase 2) noted:

*I think it has enabled us to connect with human beings in our population, and wrap our services around them in a way that we believe truly meets their needs as human beings, and doesn't look at things in isolation but starts to look at them as individuals with complex lives in a place setting, and think about how we respond accordingly.*

Elected Members could make links across different areas of local authority activity so that, for example, healthy lifestyle services were not being commissioned in isolation but tied into initiatives in schools and the wider community. A DPH commented that:

*I've been really impressed by the top councillors that they can see linkages back into the community and other elements. That just being in the NHS probably inevitably you just don't do. So they see linkages I don't see. And that's great, really very impressive. They might link to schools or just think in a different way. So I think that's a real added value that councillors, good councillors can bring.*

Moreover, 'community insight' was described as key to effective interventions: public health interventions needed to be rooted in the realities of local communities and linked to local assets.

Interviewees across most sites (including CCG as well as local authority interviewees and encompassing sites with different political control) emphasised the importance of encouraging communities (of both identity and of place) to help themselves, through asset-based community development (ABCD), that is, developing 'community assets' and finding ways of building community capacity. This could include: community link workers mapping (and linking) assets in the community; volunteer involvement in local neighbourhood networks (with volunteers trained in mentoring, for example, or in providing healthy eating advice); front-line staff; community health champions, dementia friends and heart champions - one site claimed over nine thousand champions. It was argued that pressures on the health and social care system from long-term conditions meant that communities had to become more involved, taking more responsibility for improving health and wellbeing. A HWB Chair (Phase 2) made the link explicit:

*And actually connecting to them and utilising them, and using them as an asset is part of the way we can deal with the financial challenges that we face.*

In one site, there were extensive volunteer networks, numbering many thousands, carrying out a range of activities including gardening, helping vulnerable people in winter conditions and addressing social isolation (helped with funding from the adult social care budget). The contribution of volunteers was recognised each year (e.g. through awards sponsored through private companies). The emphasis in this site was on community rather than on individual responsibility and was fostered by the active involvement of Elected Members. Initiatives and volunteer organisations were supported by small grants from the local authority, which saw itself as raising awareness for the community to take action to improve health and wellbeing and which was supported by employee initiatives across the public and the private sector.

Economies of scale could lead to a dearth of innovation and, in one authority, the decision was taken to create opportunities for community groups or individuals to bid to carry out innovative projects from a substantial community investment fund. This was described as a route for managing demand, for encouraging innovation and diversification and reducing a 'dependency culture', while at the same time increasing social value. It was adopted in preference to commissioning the VCSE sector. Funded through local authority reserves, rather than the public health budget, it was linked to local authority objectives, particularly in health – with almost 200 groups having benefited from this initiative. It was designed to pump-prime sustainable community enterprises, and had been used to promote physical activity, for example, working with volunteers and community groups. Support was provided through community link workers (part of whose role was to map community assets), community champions, and community connectors (based in primary care). It was described as a way of working with citizens, 'working alongside local communities to improve health and wellbeing, improve local communities, improve community cohesion'. This site had also focused on an asset-based approach to adult social care and locality planning.

Another site had used network approaches, identifying social and economic need, assets and health profiles in a ward to understand how local social networks could stimulate new responses to addressing health problems, and new ways of growing local enterprises. An Elected Member noted that while communities might not understand that they were involved in developing new services, money was being used to support community groups:

*We do believe that money used on a local basis can very often provide much, much greater return than money spent centrally. So we are trying to move money out to, not just the third sector/ voluntary sector, but also to local community groups to try and assist those.*

This could address problems such as social isolation, identified as a problem not just for older people but also for young people and recognised as having implications for public health. In other sites, community assets were highlighted as a route for getting ‘people to begin to understand what they can do for themselves’, for example, but not always supported by a strategy which included grant support for community development or the voluntary sector.

When asked for concluding thoughts on commissioning and providing preventive services, VCSE sector interviewees emphasised the importance of the VCSE sector because of its links and insight into local communities. This was summed up by one interviewee, who concluded that the VCSE sector could:

*deliver services that are appropriate to people in their locality. ... The whole potential of public health delivery being relevant and localised is what the voluntary sector is good at.*

If the purpose of the public health reforms was to improve commissioning and providing preventive services, the view of VCSE sector interviewees was that this could only be achieved with their involvement and support. However, involvement of the VCSE sector was promoted more vigorously in some sites than others.

The two national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), provided an overview of new approaches to commissioning (Table 7). Results showed that in 2016, a majority of respondents saw the public health reforms as encouraging all the factors summarised in Table 7 (with the exception of financial incentives), with very similar results across both surveys. Almost three-quarters of respondents highlighted new integrated health and wellbeing services and asset-based approaches. There was an increase (from 49% to 58%) in respondents indicating encouragement for addressing clustering of unhealthy behaviours and in the use of financial incentives for providers (from 23% to 39%). Many initiatives predated the reforms.

**Table 7: Overview of changes in approaches to commissioning: results from national surveys of DPH and CCG members of HWBs**

<b>Have the public health reforms encouraged any of the following approaches in your local area?</b>	<b>% ‘yes’ 2015</b>	<b>% ‘yes’ 2016</b>	<b>Comments</b>
Addressing clustering of unhealthy behaviours	49	58	Holistic approaches, lifestyle hubs, social prescribing, MECC
Developing new integrated health and wellbeing services	72	72	Importance of data sharing and integration of client databases, initiatives for frail older people, use of the Better Care Fund, 0-19 services
Using community networks to identify underserved groups	64	64	Predates reforms. Used to identify social isolation, community health ambassadors for cancer services, BMER groups helping to target services
Developing asset-based approaches	72	69	Asset mapping and needs assessments involving community members, tackling obesity through local assets, wellbeing hubs, whole authority strategic approaches
Using VCSE organisations to work with underserved groups	64	56	Predates reforms. ‘Men in Sheds’, projects with BMER populations; working with refugees and asylum seekers
Using financial incentives for providers	23	39	Predates reforms. Reduction in smoking in pregnancy achieved through provider incentives, Social Impact Bond to address

			loneliness through public health grant
Using local authority venues to deliver services	59	61	Already established but 'whole public sector estate used to improve access', Children's centres, community-based health and wellbeing hub, flu jabs in libraries. Adult learning colleges used for delivery of recovery programme for mental health
Using neighbourhood venues to deliver services	59	69	Already established and used for early years and age-friendly programmes, using neighbourhood managers to help deliver screening programmes

**Note:** Response rates for the surveys were low and this prevents generalisation of results. For survey one, there were 39 responses (11 CCG members of HWBs (response rate: 7.2%, 11/152) and 28 DsPH (20.7%, 28/135)). For survey 2, there were 36 responses including 6 CCG members of HWBs (response rate 4%, 6/152) and 30 DsPH/ other public health representatives (response rate 23%, 30/133)).

### 6.2.6 Impact on health inequalities

How inequalities were conceptualised and addressed reflects the above themes over targeting, integration, links to communities and to vulnerable groups. Interviewees reflected a broad range of approaches. These included: targeting preventive services (see also sub-section 6.2.4); early intervention; an emphasis on priority groups; 'consultative' rather than 'analytic' approaches; and cross-directorate initiatives which included an advocacy and social mobilisation role. These are discussed in turn.

#### **Targeting preventive services**

Identifying and reaching under-served groups is fundamental to addressing health inequalities. However, financial stringency had led to greater targeting or 'differentiated investment' and a move away from universal services, which was evident in all sites and reinforced in second phase interviews. This was reflected, for example, in targeted (and integrated) approaches to vulnerable groups, in specific services (such as smoking cessation), or in place-based approaches which targeted geographical areas with highest need. It could also be reflected in contracts for commissioned services requiring measurable contributions to the reduction of health inequalities. For example, one DPH (Phase 2) noted:

*Everything we commission from the public health budget we try and either do a health inequalities impact assessment or we actually try and explicitly target the services in such a way as to try and narrow the gap in life expectancy.*

There were, however, exceptions to the focus on targeting. In one site, following consultation, universal services for 0-5 were not being targeted, leading to enhanced universal support with more targeted support offered for children over five. Criticism was expressed by some CCG interviewees over the movement towards more targeted approaches in prevention. In addition, some NHSE interviewees were also concerned that the health visiting services, transferred to local authorities in October 2015 could, over time, be replaced by a targeted service. Concerns were expressed over a potential loss of substantial NHS investment in health visitors prior to transfer and over a change from universal services and national standards to more locally agreed and targeted services (as had already been the case in some sites, following transfer of school nursing services). An NHSE interviewee commented:

*In NHS England, there was a huge programme of work to improve health visitor numbers and commission services in a certain way. And now it's going over to local authorities. Quite understandably they're doing their things locally or procuring, and you've lost any of that*



*grip of numbers and improvements on a national level. And I think it just gets very muddy around whether it's locally based or you want some consistency of standards across the board.*

Interviewees referred to local debates over definitions of prevention and of health inequalities and the balance to be achieved across universal services, self-referral and targeted services. In one site, an Executive Director explained:

*We're working quite intensively with people who often, of course, have children, but sometimes 18-49s, you know, substance misuse, homelessness, domestic abuse and targeting actually some of the previous universal results and re-commissioning more intensive support around the deprivation areas and those cohorts of people. And we're getting some, as I say, some really good results coming through.*

In another site, a holistic model of assessment was adopted for pregnant women, including wider social and economic aspects and subsequent input was targeted to those in greatest need.

In second phase fieldwork, continued reduction in financial resources was leading to greater targeting of services. One DPH (Phase 2) stated:

*We've become much more targeted, I would say, in terms of our approach to inequalities. This kind of concept of proportionate universalism ...is still there in terms of the sense that everybody should have some support to be better from a health point of view. It's still there to a degree but it's shrunk.*

Although reductions in resources may have been an impetus for improved targeting, they also had negative impacts on action to address health inequalities. A district council interviewee spoke of targeting 'areas of greatest deprivation', and focussing on 'start of life' interventions. However, this interviewee also spoke of the area having high levels of older people who 'tended to vote and therefore the politicians they elect tend to listen to them and their concerns'. Consequently, this interviewee believed that there was a risk that a disproportionate amount of attention and resources would be focused on older people's services, to the detriment of young people.

#### *Early intervention for children*

Reflecting social determinants of health and health inequalities, and also consistent with the wider role of the local authority in caring for vulnerable children, and the role as 'corporate parent' was an emphasis on early years, as reflected in the first policy priority of the Marmot Review (2010), 'to give every child a good start in life'. Health inequalities were considered within wider inequalities, as a Director of Children's Services noted:

*So you can look at an education gap, you can look at a health gap, you can look at a social care gap, and actually they're much of a muchness aren't they?*

The 'school readiness indicator' (at age five) was emphasised in some sites as a predictor of future inequalities in health and life chances and was, therefore, a key focus for public health investment, especially where numbers not achieving school readiness were high. This could be channelled through a range of 'early help' initiatives, including children's centres. The importance for future health of early childhood development made this a key focus for public health input, as well as for public health funding where services were at risk from cuts. The transfer of services (0-5) in October 2015, allowed for an integrated approach.

### ***Refocusing on priority groups***

Interviewees often discussed health inequalities in the context of the needs of migrants, socially isolated people, lone parent families and other vulnerable groups, such as children leaving care. Health inequalities were framed less in terms of narrowing the gap in life expectancy over the shorter-term and more in terms of poor quality of life, due to factors such as mental ill health and social isolation. Reflecting their remit to articulate views of seldom heard groups, there were a number of related initiatives cited by local Healthwatch interviewees, including working with refugees and asylum seekers, addressing problems of access to dental services of people with HIV/AIDS and having 'contact' events in disadvantaged communities. One interviewee noted that insight work was being carried out with 'a couple of our hard to reach communities looking at homelessness, sex workers, for example, and going out and actually having those focus group discussions with them'. This could be reflected in a range of reporting arrangements for inequalities - for example to the Safeguarding Board, as well as the HWB and Health Scrutiny Committees. In some sites, the emphasis on premature mortality and lifestyle services, predominant in the NHS, was still prominent: in one site, for example, inequalities between different parts of the local authority were being conceptualised in terms of premature mortality with efforts to tackle obesity and smoking - adopting a personalised approach along with an emphasis on a healthy environment.

### ***Consultative approaches to evidence***

Some interviewees noted a tension between an evidence-based approach to 'narrowing the gap' and a more inclusive, consultative and participative approach. One CCG interviewee described this change as a shift from an 'analytic' to a 'consultative' approach. The former analysed causes for health inequalities and the most effective interventions for addressing them, while the latter involved an inclusive consultation with stakeholders and the public. While a 'cold' analytic approach could fail to engage, the latter approach could fail to deliver on the aim of narrowing the gap. This emphasis on communication and engaging, including with local Elected Members, was reflected in another site, where it was argued that how data on health inequalities were presented to Elected Members was key, and it was important to tell a 'good story'. A DPH noted:

*So actually if you can, if you can talk about inequality in terms that they can visualise then they become interested in it. It's when you talk about it in technical terms that it doesn't mean anything to them.*

Examples included: the annual report of the DPH being presented in pictograms, which was felt to have been highly successful in communicating data for Elected Members; regular monthly workshops on public health topics; and working closely with Members on ward-based information. It was argued in one site that the statistical input of the public health team had given 'a much broader understanding' of ward-level deprivation, and, in this site, an extensive series of ward-based meetings with Elected Members had engaged them with public health issues in their area.

### ***Cross-directorate approaches***

Aspirations for integrating a public health approach across local authority directorates are further discussed in sub-section 6.4.3. Some case study sites had long-standing commitments to addressing health inequalities, reflected in local authority plans, partnerships and through health inequality impact assessments, describing themselves as already a 'public health organisation' or 'early intervention council' and, where this was the case, it was argued that the reforms provided a continuity of approach.

Issues such as domestic violence or social isolation could be adopted as cross-cutting themes across a council, encouraging cross-directorate working for vulnerable groups. Links were made across the health inequalities agenda, improved housing and economic and regeneration initiatives. In one site, efforts had focused on employment and regeneration programmes for poorer areas, initially through

education-based regeneration programmes, but extended to include improved facilities (including play facilities) with the aim of promoting wellbeing and to 'give people a pride in where they live'. The HWB Chair noted:

*They were all replaced with brand new schools under that particular programme, and then we as a local authority decided that we would start a regeneration programme there and it was going to be education based.*

One of the advantages of the reforms was being able to build on equity impact assessments routinely carried out on all local authority plans and service changes. In one site, a service director had set up an 'equalities board' for the directorate (on which public health was represented) to ensure that all groups were being reached by services.

Less prominent was an emphasis on health inequalities impact assessment across directorates. However, there were examples of all policy statements being required to include a section on public health impact. In a local authority which had adopted this practice, the CE made clear the commitment of the local authority as a whole to public health and to addressing health inequalities:

*We're very clear in the senior management team of the organisation of the communities where there are health inequalities and our overall strategy whether it relates to employment, whether it relates to education and school performance, vulnerable youngsters, is part of that thinking about inequality in those communities. So I think we've got a bigger focus on inequalities in this organisation.*

In another site, a stream of work on health inequalities was orientated towards ensuring that the principle of proportionate universalism was reflected in mainstream service delivery 'embodied in children's services, adult social care, neighbourhood and communities, NHS primary care services...' (DPH phase 2). A public health advocacy role involved:

*all the governance and political and professional networks in making sure they understand that the challenge is, where we've got very strong forces generating inequalities, making those visible in the public domain as part of the advocacy we do, including through social media and political engagement.*

Other interviewees considered that how best to address health inequalities was a matter of debate. In one site, the Healthwatch interviewee noted that addressing unemployment had always been a priority of the local authority but, in fact, little had changed and there would be problems if all public health resources were channelled into the wider determinants of health. An Elected Member in the same site noted a similar tension:

*Our political approach to it and kind of being very candid, the best public health interventions we can make for our community are skills and opportunities for good jobs, and making sure that they have the right housing. ... You could make an argument for saying we're just going to blitz all our money into wider determinants issues. But then what happens when the phone rings and someone says 'I'm struggling to maintain a healthy weight, how can you help me?' And you say 'I can't'. You just can't do that. So those two things are in tension, they're not completely incompatible obviously, but those two things are in tension in terms of your focus. So those are the things we have our good discussions about.*

The study showed that the nature of the health inequality debate was changing, with implications reaching beyond targeting traditional preventive services to encompass broader approaches which aligned with local authority priorities.

Impact on uptake was difficult to identify, although there were examples where uptake by disadvantaged groups had been improved through opportunistic health checks, for example. The national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) explored whether service changes had increased uptake in underserved groups through a supplementary question related to topics listed in Table 7. There were increases in the percentage of respondents for all categories, with the exception of the first two categories, with a majority of respondents in 2016 highlighting community networks (from 29% to 50%), VCSE organisations (from 31% to 55%) and neighbourhood venues (from 19% to 60%). (Numbers are small, however (see RR4)).

Interviewees commented on a relative lack of support for addressing health inequalities from the NHS since the reforms, despite it being a statutory duty.

The study showed that the nature of the health inequality debate was changing, with implications reaching beyond targeting of traditional services.

### 6.2.7 Changes in preventive services since the reforms

Interviewees were asked to highlight examples of changes to preventive initiatives following the reforms. Box 1 summarises a wide range of initiatives by topic area (see also RR5). These reflect themes of new providers, social and community perspectives, integration, access, targeting of services, community-based and cross-directorate approaches, as summarised above. They also illustrate holistic approaches to community wellbeing. Further details on initiatives described as innovative are also provided in RR6.

#### Box 5: Preventive services

**Integrated healthy living/wellness services:** a wide range of models had been developed to bring together lifestyle services previously provided separately, including voluntary sector input, GP-led services, and a range of other providers. For example, an integrated wellbeing service in one site was described as a ‘well-used resource’ that brought together full lifestyle checks with other council resources to reflect a ‘broader sense of wellbeing’ including, for example, counselling support, health trainers and debt advice. A range of different options was offered. Leisure staff could be located in GP practices to increase referrals.

**Access to lifestyle services and/or social care:** (a) telephone hub for referral to lifestyle services; (b) clearing house for referral to lifestyle services with choice of providers; (c) advice and access to lifestyle services from a shopping centre in a deprived area; (d) locality-based, one-stop-shop wellbeing services for referral from GPs, covering a wide range of lifestyle services, including help for depression, anxiety and obesity, and links into council services; (e) health and wellbeing hubs at district level, acting as a signposting facility and providing lifestyle (and some drug)-related services and social prescribing, working in liaison with district housing (funded through the public health grant).

**Exercise and leisure:** (a) free weekend swimming (predates reforms), shown to increase uptake amongst disadvantaged groups; (b) walking group for Asian women; (c) parks activities include guided walking, also with impact on social isolation and underserved groups; (d) free leisure activities on GP referral; (e) park rangers organising walks for older people (if referred from the NHS); (f) Healthy walks – could lead to development of community assets through making contacts between people; (g) joint work across district council and charity to ensure parks and beaches are well used; (h) ‘Good gym’, a ‘purposeful use of energy’, via a social enterprise, where people run between good deeds to help people referred from social services (via Instagram); (i) encouraging women to get involved in sport and exercise; (j) outdoor gyms; (k) Green gym (promoted through council website); (l) street dance in schools (funded by public health grant); (m) exercise in school breaks and early morning exercise with teachers before school starts (externally funded); (n) basketball court; (o) weight management: incentivising overweight, middle-aged men to improve health through joining a football league (which had good results).

**Food and healthy eating (see also section 6.3):** (a) raising awareness about sugar; (b) volunteers setting up ‘cook and eat’ sessions in community venues; (c) targeting weight management services in areas of high deprivation; (d) contacting restaurants over levels of salt and fat; (e) encouraging local food manufacturers to

produce healthier food (e.g. healthier pies); (f) further development of weight management services and single access point for residents for a wide range of weight management programmes offered by different providers and also targeted to groups less likely to engage; (g) growing food in schools for school kitchens; (h) free hot meals in park, run by volunteers, in a deprived part of the borough; (i) community-based diet and physical activity service; (j) food summit (including public health and the voluntary sector); community food classes (as part of adult education), bringing families together.

**Smoking and tobacco control:** smoke-free play areas.

**Drug and alcohol services:** (a) re-commissioned from a highly professionally-dependent drugs and alcohol service into a more community-orientated model, also using volunteers; (b) more emphasis on peer support and looking at impact on children, combining third sector and NHS providers; (c) 'Water angels' promoting a glass of water after each alcoholic drink, where 'models dressed in white with wings' go into pubs and clubs. An interviewee noted that 'the police love it. The bars love it. And it's evaluated extremely well'; (d) change from a traditional drugs service (with one provider), an alcohol service (with a different VCSE sector provider), plus small contracts (with pharmacists), to a single integrated contract for substance misuse.

**Sexual health services:** (a) integrated sexual health services, tied in with VCSE sector for the targeted aspect; (b) use of online information, which resulted in a drop in demand for services; (c) initiatives to take account of cross-boundary issues, especially in London where accessing services in central London could double the cost to the local authority; (d) CCG funding of voluntary sector input into sexual health services; (e) moving services out of the hospital into the community (resulting in a 27% increase in people attending appointments and a 24% reduction in the cost of the appointment); (f) reframing sexual health services as a continuum with healthy relationships at one end (and also linked to prevention of domestic abuse) and clinical services at the other.

**Offender rehabilitation:** restoration projects.

**Care service:** provided through a community-based health and social care charity to include a healthy living centre (and including health checks). Proved successful in reaching disadvantaged groups and funded through a range of commissioners and grant-giving bodies.

**Health campaigns:** council-led health campaigns across a city.

**Incentive schemes:** (a) social impact bond, where a proportion of the saving to the health service from a healthy living charity is recycled and pays for the activity; (b) higher rate of payments for smoking cessation for those in manual occupations.

**Integrated services for children:** (a) school nursing and health visitor services and (Child and Adolescent Mental Health Services (CAMHS) provided in an integrated way through a private provider; (b) redesign of health visiting and school nursing, involving skill mix changes, a focus on outcomes and working across local authority services, such as children's centres, in order to provide an integrated service; (c) Lottery-funded projects for children, to give the best start for disadvantaged children in highest demand areas.

**Children and young people's services:** (a) online counselling services for children and young people (predates reforms); (b) healthy schools programmes and teams; (c) a central team supporting schools, including for emotional health; (d) interactive online drama, developed through workshops, allowing young people to play out dramas online and outcomes are filmed, based on the young person's decisions. Topics include gang violence; (e) initiative across the CCG and local authority to encourage primary school children in disadvantaged areas in use of inhalers, to reduce hospital admissions for asthma; (f) recycling through a schools initiative, thereby influencing parents; (g) National Child Measurement Programme followed up with family-based intensive support, taking account of social and economic circumstances of the family; (h) digital emotional health and wellbeing services: tier one/tier two service for children and young people.

**Information sources:** all Citizen Advice Bureau users were asked if they had areas of concern related to health or social care and information is communicated to local Healthwatch (and through them to commissioners, if relevant to health and wellbeing).

**Community projects/facilities:** (a) developing community centres in deprived areas (Lottery funded) with a wide range of services (from selling fresh fruit and vegetables to line dancing); (b) community ownership of leisure facilities; (c) community projects for physical and mental health, including community drumming, social enterprises, singing group for those with long-term conditions.

**Gardening groups:** (a) using volunteers (plants provided by the local authority) which promotes exercise, improves the area and reduces vandalism and antisocial behaviour; (b) dementia day care combined with allotment/gardening activities; (c) gardening and environmental activities for people with mental health problems. These sometimes reflected local authority investment in community assets.

**Training initiatives:** training in brief interventions (e.g. for alcohol) plus an app to help those carrying them out and signposting to relevant services.

**Social isolation:** (a) social enterprise tackling social isolation and 'driven by local entrepreneurs', where referrals can be made through health and social care (public health funding used as catalyst); (b) library-based activities (e.g. knitting groups); (c) developing community capacity and setting up community groups for befriending services and supporting development of community centres.

**Heart Health:** borough-wide initiative.

**Healthcare public health:** using the public health grant to pump prime identification of people with atrial fibrillation in general practice.

**Healthy business awards**

**Healthy Living Pharmacy programme** (local authority funded)

**Online services:** (a) 24/7 counselling for young people plus one-to-one support offline and chatrooms (funded through the local authority); (b) online services for sexual health, emotional health, healthy lifestyles. In one example, healthy lifestyles support was accessed through the internet or by telephone only with no other support with the exception of small targeted smoking cessation service. The service was developed following focus groups, identifying different types of users; Apps for weight management and for quitting smoking.

**Social prescribing:** (a) community link workers in primary care; (b) social prescribing funded by CCGs and delivered by the voluntary sector; (c) social prescribing project, mainly for people with mental health problems.

**Targeting of services:** (a) targeting services to ensure higher take up from those with greatest levels of need; (b) health trainer services only available in disadvantaged areas of the borough.

**Wider public health workforce:** fire service providing health promotion services.

**Wider public health advocacy:** supporting organisations to undertake challenges to multinational corporations with interests in promoting unhealthy products to children.

**Local authority workforce:** (a) health checks; (b) wellbeing charter

While these initiatives illustrate a wide range of approaches, many predated the reforms and changes were difficult to discern, as pointed out by one interviewee:

*If a whole new team had arrived in 2013 and I'd got introduced to a whole new bunch of people and they had a completely different approach, then I would be able to say 'oh well, that changed and that changed and that changed'. But it's very hard to discern, you know, what changed on the ground and what changed in terms of relationships because, actually, by and large, it's more of a continuum.*

In the same way, some public health departments had previously worked closely with local authorities and the voluntary sector, including in one case, 'working with residents at the kind of neighbourhood level of being involved in community development work'. The reforms had not led to great changes, although it was argued that this might not be the case for authorities where the public health department had no history of partnership work for community development.

### 6.2.8 Community engagement and co-design

One of the rationales for the reforms was that local authorities were closer than the NHS to local communities, with well-established routes for community engagement and co-design. Some interviewees considered that public health services had often adopted an intervention model which involved 'doing things to people' rather than working with them and that interventions should be rooted in broader community-based activities already in place. Apart from changes in contracting and in choice of provider, there were, therefore, differences in how services were being commissioned, with more emphasis on co-design, rather than on early specification of the contract. This was seen as a route for improving the efficiency of commissioning. A DPH commented:

*That's what the NHS does not do. It does not engage its users in an active discussion about where it can get efficiencies out of the system. It just doesn't do it.*

Local authority engagement mechanisms were extensive. Engagement was promoted through Elected Member involvement in their wards and local area committees and there were examples of working with Elected Members to help identify commissioning priorities for healthy lifestyles. There were also specific consultation mechanisms for particular groups. For children, for example, there could be a youth cabinet, youth forum, young health champions, youth parliament and school councils, parent/carer groups in children's centres, a 'children in care' council, involvement of parents and young people in designing services for children with disabilities, initiatives to involve young people in mental health services redesign, and electronic systems for user feedback for children and adolescents. There were citizen's panels and groups for those with particular needs, such as people with learning disabilities and parents and carers of children with disabilities. Other routes for engaging with local people included community health champions, patient participation groups, and members of NHS Foundation Trusts, faith networks, amateur sports clubs and ad hoc targeted groups. One site reported over 2000 community health champions working with community groups.

Co-design of services and extensive consultation arrangements were already well-established as part of commissioning processes in local authorities and it was argued that public health teams could benefit from the links that were in place with local communities and with schools. Sexual health services, drugs and alcohol services and 0-19 services were all described as having been re-commissioned through co-design. Local Healthwatch had specific engagement contracts in some sites and had developed engagement strategies for children and young people, for example, in addition to carrying out their mandate of providing a voice for seldom heard groups such as asylum seekers and refugees. Interviewees also argued that the creation of CCGs as part of the reforms had also helped promote co-design. Practice-based patient participation groups were in place and in one case, groups were being linked across neighbourhoods with planned involvement in neighbourhood development.

There was a view that services transferred from the NHS would benefit from greater engagement, with health visiting cited as an example. One interviewee commented:

*We're about to do a survey of parents who use health visiting services to really find out what benefits they see from the service, what they would like to be different, the kinds of questions that they want to ask health visitors and the sort of issues that they want support with, so that we can think about how we do that differently in the future.*

Interviewees highlighted greater engagement since the reforms in relation to the Joint Strategic Needs Assessment (JSNA) and co-design of services. These are discussed in turn.

### **Community engagement in the JSNA**

Interviewees in some (although not all) sites considered there was greater community engagement in developing the JSNA since the reforms. A DPH noted:

*So in terms of our JSNA chapters, our needs assessments in terms of commissioning services, we've probably consulted with local people and with stakeholders, probably more broadly than we might have done before because of that relationship. It's still developing, so our councillors are very interested in supporting the commissioning of local services.*

A VCSE sector interviewee from a site that did not have VCSE sector representation on the HWB nonetheless believed that there was now wider stakeholder engagement and co-production, giving an example of the process to refresh the JSNA. The interviewee was a member of a JSNA review board and consequently had an 'opportunity to feed in and to have discussion and debate'. The

ability to influence was mentioned by other interviewees, through public health attending VCSE forum meetings, consulting on the JSNA and through face-to-face meetings with small groups. However, there were also interviewees who felt that there was less 'ongoing dialogue' and fewer opportunities to influence. One interviewee also observed that, even though public health had a culture of:

*informing us of their good ideas and where they want to go; what they're not at all good at is real consultation ... . There's never, never really been challenge and a real consultation saying 'seriously, blank piece of paper, what do we do?'*

In another site, there was community engagement in discussion of HWB priorities, including: 'Health talk' events in order to discuss strategic priorities and the allocation of resources; a public website with discussion threads; and local community organisations gauging community insight (funded through the public health budget). In one site, it was planned for localities to have their own HWBs. A CCG interviewee stated:

*So we'd be hoping to bring the leaders across localities together. So that would be your local councillors, wouldn't it? It would be general practices as commissioners and providers. And that would be interesting.*

In a further site, the annual DPH report was being presented as a film, rather than a written report, involving local people and drawing on the experience of community champions.

Scepticism was expressed by some interviewees over whether there had been changes in services as a result of greater engagement since the reforms. Local Healthwatch and VCSE sector interviewees were sometimes critical of the level of engagement with public health teams and of willingness to build on research carried out through the sector. In one site, local Healthwatch considered that public health was 'remote', not aware of what life was like 'on the ground' and Healthwatch, therefore, wanted more input into providing information for communities.

In second phase fieldwork, one DPH emphasised that the qualitative aspect of the JSNA and of separate needs assessment had been maintained through focus groups, special interest groups, a joint engagement board and ethnographic studies.

### **Co-design of services**

One reason for community involvement was to establish priorities for funding through finding out what support was needed and where services could be delivered differently. Commissioners needed close links with communities in order to develop the new community hubs, for example. There were examples of co-design across midwifery, youth and mental health services, along with web-based services created and designed by young people. Other examples of co-design highlighted by interviewees are included in Box 6.

#### **Box 6: Examples of co-design**

- 'Experts by experience' programme in adult social care;
- Services for sexual health and for drugs and alcohol: 'a co-design piece ... I think the drugs and alcohol one was probably the most recent one where people were more actively involved in it';
- Substance misuse services: (a) 'substance misuse service, domestic violence service will be co-designed absolutely with a strong input from the beneficiaries, even bigger than that, the perpetrators in terms of some of the services'; (b) redesign of a substance misuse model of delivery via a co-productive approach which led to a revised local substance misuse Integrated Prevention and Recovery model and informed a new tender; (c) recovery model for a drugs and alcohol service where those in recovery volunteered to support the next group coming through;



- Re-commissioning of CAMHS, where young people had been fully involved and which had led to a different delivery model and a different provider;
- Working with over 100 organisations to help design healthy lifestyle services;
- Healthwatch initiatives through specific engagement contracts and work with young people and seldom heard groups;
- Future plans for BMER dementia services attended by 200 people;
- Engagement work by public health over six months for an 'emotional health and wellbeing JSNA' included work with Asian heritage young people who were trained as 'engagement practitioners'. These young people then recruited and carried out interviews with 25 other young people from their community or social networks. Interviews were audio taped and transcribed, and this data was then included in the final analysis;
- Network approaches to identifying social and economic need involved mapping of social networks, assets and health profiles in a ward area to understand how local social networks could stimulate new responses to addressing health problems, and new ways of growing local enterprises. A team of community researchers surveyed local residents and local residents were involved in interpreting and making use of the findings. A range of latent community resources was identified;
- Focus groups involved in developing new digital healthy lifestyles service.

Co-design could itself lead to the development of community assets and the links between them were illustrated by one interviewee in relation to dementia support:

*I never quite foresaw the extent to which they would then become assets in their own right. You know, so they are people who are now going on to set up their own community interest companies and they're becoming dementia trainers and they're getting jobs and it's fantastic, really.*

It was difficult to assess the extent of co-design or its impact on services. CCG interviewees in two sites were sceptical over whether services had actually changed, despite the emphasis on co-design and on engagement, and a Healthwatch interviewee commented:

*I always say I think our work will really move on when people believe that co-production is actually a better way of doing things and will produce a better outcome for the service and for patients as opposed to it being what we have to do at the moment, and I think that individuals are on their own trajectory with that.*

The question of co-design was also explored through national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)). As demonstrated in Table 8, a higher percentage of respondents answered 'more' for each category, in 2016, indicating that the reforms may have encouraged greater participation by communities in preventive services, an activity identified with encouraging innovation. Increases were greatest for 'identifying local public health priorities' (from 23% to 39%), 'community capacity building' (from 36% to 53%), 'influencing commissioning priorities' (from 31% to 44%), 'co-design of adult services' (from 33% to 42%) and 'co-design (young people's services)' (from 41% to 53%). While the direction is consistent, encouragement of co-design is not identified by a large majority. In national surveys of Healthwatch and VCSE sector members of HWBs and VCSE organisations involved in health promotion and prevention, a majority did not identify improvements in co-design, in public involvement in commissioning or in influence over the JSNA.

**Table 8: Impact on co-design (surveys of DPH and CCG members of HWBs)**

To what extent have the public health reforms affected participation by local communities in your local area in the following activities?	% 'more' 2015	% 'more' 2016	Comments/examples
Identifying local public health priorities	23	39	Small grants available; focus groups; board membership; HWB stakeholder events
Identifying local solutions	39	44	Local area partnerships
Community capacity-building	36	53	Integrated wellbeing services
Influencing commissioning priorities	31	44	
Co-design of adult services	33	42	Sexual health, domestic abuse
Co-design of young people's services	41	53	Suicide prevention strategy. Pathway for emotional health and wellbeing

**Note:** Response rates for the surveys were low and this prevents generalisation of results. For survey one, there were 39 responses (11 CCG members of HWBs (response rate: 7.2%, 11/152) and 28 DsPH (20.7%, 28/135)). For survey 2, there were 36 responses including 6 CCG members of HWBs (response rate 4%, 6/152) and 30 DsPH/ other public health representatives (response rate 23%, 30/133)).

### 6.2.9 From problem to place: changing the focus from problem-based commissioning to influencing community wellbeing across the place

Many of the projects outlined above illustrate how different approaches were being integrated, so that unhealthy behaviours were not considered in isolation from each other or from the social conditions associated with them, and individuals were not considered in isolation from families and local communities. The national survey of VCSE organisations involved in prevention showed that for the 39 respondents, the most commonly mentioned preventive services they provided were linked to outreach, community development and addressing social exclusion, mentioned by over a third of respondents, while 15% or less mentioned services reflected in the public health budget categories.

A number of interviewees highlighted the shift from commissioning preventive services to public health influencing local authority policies and strategies, combined with a focus on factors influencing health and wellbeing across 'the place'. This was associated with a range of wellbeing projects, which combined different problems and interventions through community-based initiatives. A DPH described this shift in how commissioning was conceptualised as 'thinking less about the budget and the particular issue, and more about moderating, mediating, informing and enabling, supporting the individual in the way that they live their lives. And a lot of that comes down to education, employment, accommodation'. More broadly, it was emphasised that public health teams formed part of the wider reform of the public sector and of promoting 'public value'. One CE described this as follows:

*It's really important, I think, that public health connects into a wider movement for change, i.e. public service reform, not just around health but around broader wellbeing and employment, housing, leisure, happier lives really. That's how I would define public health. I think the advantages are that it can easily dovetail into other things that are ongoing on in public service reform.*

### 6.2.10 Conclusions

In summary, commissioning decisions are influenced by a wide range of factors - from budget constraints at one end of the spectrum to views over the intrinsic value of lifestyle interventions at the other. This section showed how local authority commissioning processes were being applied to preventive services with more emphasis on value for money, diversity of providers, outcomes and clearer specifications. Preventive services were being re-commissioned and also reduced. Preventive services were more likely to emphasise social and community aspects and were increasingly targeted, integrated and aligned with local authority priorities. While there was greater

targeting of services, the proportion of spend across the budget categories was considered relatively constant.

There were clear differences between sites over the extent to which the VCSE sector was seen as a major route for understanding and engaging with communities. In two sites, there was more emphasis on the role of the local authority in directly engaging with its communities rather than the role of the voluntary sector and this was reflected in the membership of the HWB where the VCSE sector was not included.

Building community capacity was emphasised as a route for managing demand, encouraging innovation and increasing social value. Health inequalities were often considered in the context of wider inequalities and cross-directorate approaches focusing on early intervention for children, targeting strategies and needs of vulnerable and priority groups and local context. Public health services could draw on well-established local authority engagement processes and there was greater community engagement in JSNAs and more emphasis on co-design, especially for sexual health services, emotional health and wellbeing and substance misuse services. Community wellbeing initiatives combined different approaches, rather than viewing problems in isolation.

Financial restrictions were contributing to a focus on whole system approaches rather than on the narrower commissioning of preventive services – ‘changing in a different way’. This was reflected, for example, in developing Joint Health and Wellbeing Strategies (JHWSs) that were broader in scope, place-based approaches, and encouraging proportionate universalism throughout all strategies.

### **6.3 NHS Health Checks and childhood obesity**

The study explored NHS Health Checks (6.3.1) and childhood obesity (6.3.2) through national surveys of DPH and CCG members of HWBs, first and second phase fieldwork and through regression analyses of the effects of spend on outcomes.

#### **6.3.1 NHS Health Checks**

NHS Health Checks are offered once every five years to people aged 40-74 not already receiving treatment, to assess vascular disease risk and refer accordingly. The programme links with other preventive programmes, including the recently implemented NHS Diabetes Prevention Programme. Local authorities assumed responsibility for NHS Health Checks in April 2013.

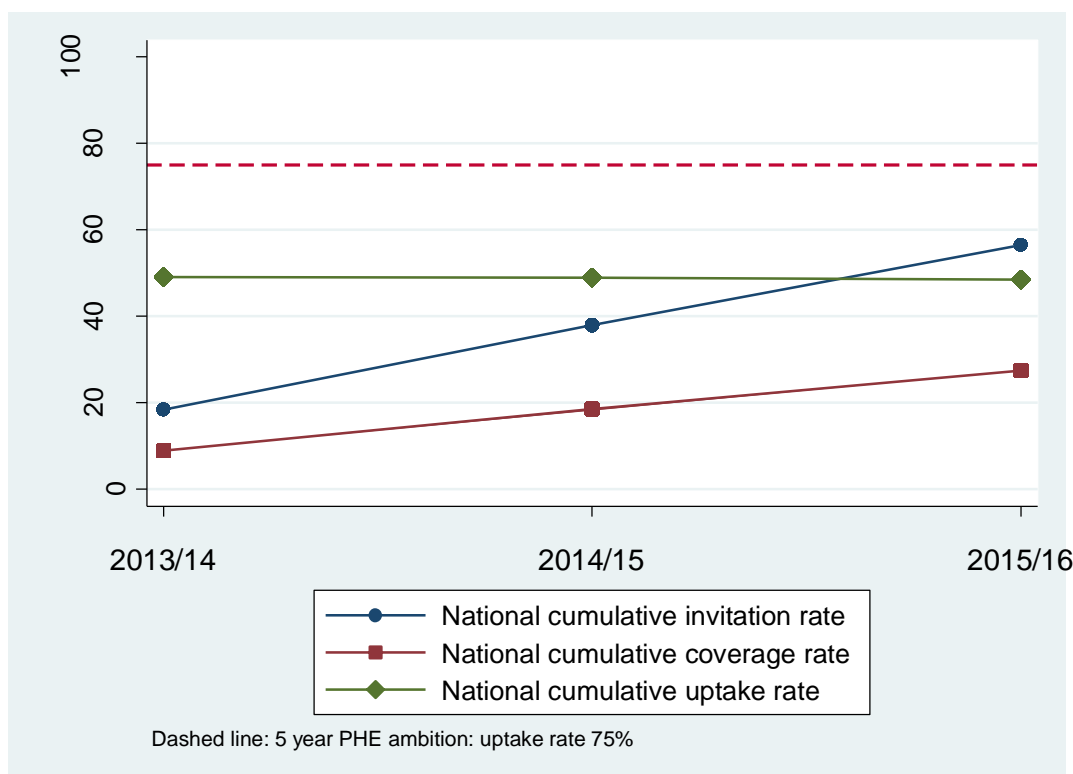
It is a mandated service and local authority responsibilities include: commissioning the risk assessment element of the programme (mandatory); monitoring offers made (mandatory); monitoring and seeking continuous improvement in take-up (mandatory); promotion/branding of the programme; and risk management and reduction (including lifestyle interventions) (LGA, 2013). Although a universal programme, with local authorities expected to offer health checks to the eligible population, PHE ‘supports approaches that prioritise invitations to those with the greatest health risk’ (PHE, 2016) and the health check is designed to be delivered in different settings to promote outreach.

Local authorities can commission services from primary care, alternative providers or some combination of the two. Health checks are locally audited, uptake is reported nationally and overall spend is reported as part of the public health budget returns to DCLG by each local authority. Nationally, around 50% of those who receive an invitation attend for a check (see Figure 3), and studies show that uptake typically increases with age (Cochrane, 2013). GP practices can decline to carry out health checks and there is great variation across every element of the process, including invitational approach, follow-up of non-respondents, numbers assessed, existence of high risk

registers, training of staff, level of detail in recording data and in onward referral/signposting to lifestyle services. While the programme can be extended beyond the eligible population, these individuals are not included in quarterly data returns.

As well as being investigated through surveys and fieldwork, this topic was the subject of a detailed analysis of national data that explored the impact of public health spend on outcomes. This section begins by describing interviewee accounts and survey findings and then investigates, through regression analysis, the relationship between spend, uptake and coverage at a national level.

Figure 3: NHS Health Check – national progress against 75% PHE ambition



Interviewees commented on how and where checks were provided, uptake of the programme overall and by disadvantaged groups and whether this service could be maintained in the context of reduced budgets. However, many interviewees did not have detailed knowledge of the programme, suggesting that discussion in HWBs and strategic development across partners was limited.

**How and where health checks are provided**

Health checks were provided through primary care (or through a GP federation) in all sites, while community pharmacies ‘played a role’ in four sites and another site described targeted involvement through the mental health trust. Some sites had made attempts to integrate health checks with other public health activities within primary care as healthy lifestyle services were re-procured, or as part of integrated health and wellbeing services, ‘so that they aren’t seen as a one off intervention’ (DPH). One site had a pooled budget for health checks across the CCG and the local authority (although surveys suggested this was unusual), while another had passed the budget for health checks (except outreach services) to the CCG.

Outreach activities, involving other providers, were described in all but two sites, covering locations such as supermarkets, town centres, leisure centres, libraries, roadshows, farmers’ markets, well-point kiosks and mobile health checks around estates, workplaces and through a health check bus. Additional initiatives were targeted at groups unlikely to receive invitations, such as traveller

communities, and groups identified as high risk but not on disease registers. In one site, the service was being re-procured to provide access outside working hours. There were also technology-based initiatives: one site encouraged referral to lifestyle services through an interactive programme, using tweets as reminders, while another offered apps for weight management and for smoking quitters which supported the health checks programme.

A DPH described provision of outreach services through a local not-for-profit organisation:

*They're an outreach service so they go out and find people in the age range in the most disadvantaged areas. So they'll be looking at black and minority ethnic groups or... traveller populations for example. So they'll be going out and looking and going into the most socioeconomically deprived areas where we know that people are less likely to respond to an invitation from their GP. And we've got evidence that that approach works, but it's expensive.*

Another DPH described initiatives to improve access for younger age groups:

*... the intelligence we got, we were getting really good uptake in the over 65s. So the reason we're offering health checks through our [name] shops, and we've got two of them. One in [name] centre and one in [name] town centre, which are very well utilised. Simply walk in.*

A minority of sites were highly supportive of the health checks programme and also encouraged self-management for healthy lifestyles through the activities of practice nurses or providing easy access to follow-on services through integrated health and wellbeing services or health trainers. There was also an example of leisure centre staff being trained to carry out health checks. Moreover, some sites did not turn anyone away from health checks, with mini health checks being provided for younger age groups. Another site had improved uptake in areas of disadvantage and a further site had concentrated on targeting younger South Asians.

One site placed particular emphasis on supporting GP practices, improving uptake for those at risk and then linking these target groups into new integrated healthy lifestyle services (which were being re-commissioned). This was informed by an analysis of records from all GP practice registers facilitating a focus on higher risk groups (e.g. smokers or those with pre-diabetes) and linked to new integrated healthy living centres as well as to the National Diabetes Prevention Programme and other screening programmes.

In a further site, the HWB Chair had been publicised having his health check, part of a culture where Elected Members were involved in promoting public health issues. In this site, for example, the HWB Chair felt the health check should be less restrictive and made available to younger age groups or those on risk registers. In two sites, the health checks programme had been scrutinised through the Scrutiny Committee.

### **Future of health checks**

Sites showed different levels of engagement with the programme. At one end of the spectrum was a combination of GP provision, extensive outreach services (sometimes provided through social enterprise) and integration with healthy lifestyle services. At the other was scepticism about the programme's value for money and effectiveness in reducing inequalities, combined with implementation challenges due to attrition from GPs and restricted provision of follow-on services. Interviewees and survey respondents noted that while it was mandatory for the local authority to commission health checks, it was not mandatory for GPs to provide them.

In both phases of fieldwork, the sustainability of universal health checks was questioned, given cuts to the budget. As for lifestyle services, there was movement towards a more targeted approach. A DPH (Phase 2) commented:

*I think, overall, we will be spending less. But we will be spending as much as we can on people who have previously not been screened or not had their health check previously. One very practical example is that we are working with our mental health trust to provide health checks for people who are in receipt of mental health services. So again that's a much more targeted approach.*

As discussed in sub-section 6.1.3, some interviewees considered that the evidence base was not as robust for health checks as for other, non-mandatory, services such as smoking cessation. DsPH differed in their views regarding the overall efficacy of the programme. The DPH who had evidence that their targeted service 'works, but it's expensive', also believed that 'there's still a national concern from the directors of public health about whether they [health checks] represent value for money'. However, the DPH (Phase 2) who experienced difficulty engaging GPs in the delivery process stated:

*I can't think of a better thing for practices to be doing [than health checks]. Whether this very structured, whole population process is the best way of doing it is another question, of course.*

Moreover, GPs in some sites were described as not geared up to managing cardiovascular risk or carrying out prevention at scale. A DPH (Phase 2) commented:

*Well, it's primary care just hasn't got its act together. When primary care starts to work at scale, when we start to have these integrated care organisations, and we have super practices and we have federations and community-based care networks, it will start to happen. Because ... that's when you're able to start to systematically deliver prevention.*

While uptake of the risk assessment might be high, referral to primary care services following the health checks was identified as problematic. The same DPH commented:

*So we've had two audits that have shown that you identify these people at risk, and then we don't do anything about the risk.*

In three sites, the programme was described as poorly supported, poor value for money or as being reduced. A further site reflected low uptake in areas of disadvantage.

One HWB chair stated:

*The CCG provide I think pretty rich information about precisely who is and isn't taking it up and it maps very clearly with our poorer communities.*

In one site, health checks were considered 'unaffordable': the in-year cuts to the public health budget had eliminated the entire reserve budget and the former PCT had failed to invest in health checks. Universal health checks through general practice had been temporarily suspended due to low impact on health inequalities in comparison with other services and in a context of budget cuts. In another site, smoking cessation was considered a more important service and for this reason,

health checks would not be prioritised, beyond sending an initial invitation letter. Although recognised as a mandated service, one DPH (Phase 1) commented that:

*It may come to the point when we even target where we send the letters. So someone in central government will say 'hang on, you're not making a universal offer and that's what you are supposed to do in the health and social care [act]'. And we'll say 'OK, so jail us', you know ... are you really saying you want us to stop the smoking cessation service in order to get a few more people through Health Checks? So we will call their bluff when we come to it – that's where we've reached.*

### **Follow-on lifestyle services**

Success of the health check programme in preventing premature mortality depends on easy access to follow-on services for those identified as at risk, such as through lifestyle referral hubs. These potentially cover a wide range of services, a choice of providers and referral to other local authority services. While hubs were funded through the public health budget, provision of follow-on lifestyle services is not mandatory and some sites no longer provided free follow-on services, such as for weight management. National surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) showed that funding from the public health budget for health checks was considered adequate by 69% of respondents in each survey, but this was not the case for lifestyle services, especially those related to obesity and exercise.

### **Analysis of national spend and outcome**

As part of the tendering process, DH requested that the relationship between spend and outcomes should be quantified. As local authorities became responsible for commissioning health checks only in April 2013, the aim of the regression analyses is to test for a relationship between spend and 'intermediate' outcomes. The rationale is that programmes designed to prevent vascular disease would not be expected to have morbidity or mortality impacts in the short term.

While the health benefits of general – untargeted – health checks have been questioned (Krogsbøll, 2012), both the viability and impact of the programme on health outcomes depend upon individuals attending for checks in sufficient numbers (Gidlow, 2014).

PHE's five-year national ambition is to invite 100% of eligible individuals for an NHS health check, and to ensure that 75% of the eligible population receives a check over that period. There are three key metrics against which performance on the programme is assessed:

1. Invitation rate: invitees as a proportion of the eligible population;
2. Coverage rate: attendance as a proportion of the eligible population;
3. Uptake rate: attendance as a proportion of invitees.

Once all individuals have been invited, the coverage and uptake rates become equivalent because the eligible population (denominator for metric 2) and numbers invited (denominator for metric 3) are identical.

### **Methods**

We analysed the relationship between annual local authority data on health check programme expenditure and these three outcomes.

The dataset covered the first three years of local authority commissioning of the programme (2013/14 to 2015/16). Data sources comprised administrative and survey data. PHE publishes national data on counts of individuals eligible for, invited to, and attending a health check in each

local authority.<sup>2</sup> The government publishes annual local authority expenditure data for each of 18 public health categories (20 categories in 2015/16) and for total public health spend.<sup>3</sup> ONS population estimates were used to derive per-capita values of expenditure,<sup>4</sup> which were then used to derive terciles of spend (low / medium / high). Both measures of spend were tested in the models, as well as programme spend as a percentage of total public health expenditure. Per capita values were based on the relevant population, e.g. people aged 40-74 for spend on the health check programme.

The selection of control variables was informed by a literature review, with measures derived using data from the 2011 Census, National Statistics,<sup>5</sup> GMS,<sup>6</sup> the PHOF<sup>7</sup> and Quality and Outcomes Framework (QOF).<sup>8</sup> We also included a binary variable capturing whether the local authority chose the default NHS Health Checks option in the 2014/15 Health Premium Incentive Scheme (HPIS), and adjusted for class (type) of local authority. Control variables were grouped using Andersen's Behavioral Model of Health Services Use (i.e. predisposing factors such as age; gender; enabling factors; and need factors).

We ran count (negative binomial) panel models with local authorities nested within years and ran a series of robustness checks. An evaluation of the impact of the reforms on health inequalities was not feasible due to a lack of ward-level data on health check invitees and attendees.

### *Key Findings*

On average, local authority expenditure per head of eligible population on the NHS Health Check programme ranged from £4.16 (2015/16) to £4.46 (2014/15). Mean spend per adult on tackling obesity was £1.64, with a similar level of spend on adult physical activity (£1.73).

Over the first three years of local authority commissioning, 57% of the eligible population was invited to a Health Check and 28% of the population attended. An increase of 1 percentage point in per capita spend on the programme was associated with an increase of 4% in both the invitation rate and coverage rate. However, spend had no effect on the annual uptake rate, which remained stable at 49% over the three years of the study. Key findings on the expenditure variables from the analyses are shown in Table 9.

The invitation rate is approximately in line with PHE's five-year ambition, but uptake appears unresponsive to changes in the level of expenditure. In analyses that controlled for the local authority invitation rate, the association between spend and coverage rate was smaller but remained statistically significant. These analyses provide some support for initiatives identified in the case study sites, insofar as alternatives to formal invitation, such as opportunistic checks in work places, pharmacies or sports centres, appear effective in increasing attendance rates.

Aside from the expenditure variables, we controlled for a number of other factors. In the analyses of uptake, the proportion of people of white ethnicity was not a significant driver. The effects of rurality were mixed, with some sensitivity analyses finding a small negative association with uptake. No analysis found a significant effect for participation in the HPIS, but better performance on the obesity domain of the QOF was linked to higher uptake within that locality. Compared with the

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<sup>2</sup> <http://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data>

<sup>3</sup> <https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing>

<sup>4</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/>

<sup>5</sup> <http://www.neighbourhood.statistics.gov.uk/dissemination/>

<sup>6</sup> [https://data.gov.uk/dataset/general\\_and\\_personal\\_medical\\_services\\_england](https://data.gov.uk/dataset/general_and_personal_medical_services_england)

<sup>7</sup> <http://www.phoutcomes.info/>

<sup>8</sup> <http://content.digital.nhs.uk/qof>



proportion of the eligible population who were aged 40 to 44, local authorities with higher proportions of 50 to 54 year olds had lower rates of uptake, and the same was true of authorities with a higher proportion of the population aged 65 to 69. No other age groups significantly predicted uptake. Class (type) of local authority was unrelated to uptake rates, as was the number of general practitioners per head of population.

Table 9: Key results from the regression analyses –impact of spend on outcomes

	Model 1: Invitation rate		Model 2: Coverage rate				Model 3: Uptake rate	
	IRR	95%CI	Without for invitation rate	controlling for invitation rate	Controlling for invitation rate	IRR	95%CI	IRR
Per capita spend, NHSHC: medium	1.168 <sup>***</sup>	[1.087,1.255]	1.198 <sup>***</sup>	[1.123,1.278]	1.139 <sup>***</sup>	1.139 <sup>***</sup>	1.044	[0.985,1.106]
Per capita spend, NHSHC: high	1.288 <sup>***</sup>	[1.182,1.404]	1.260 <sup>***</sup>	[1.166,1.362]	1.145 <sup>***</sup>	1.145 <sup>***</sup>	1.003	[0.935,1.077]
Per capita spend on NHSHC (£)	1.040 <sup>***</sup>	[1.027,1.054]	1.037 <sup>***</sup>	[1.024,1.050]	1.020 <sup>***</sup>	[1.008,1.032]	0.997	[0.985,1.009]
% total PH spend: NHSHC	1.061 <sup>***</sup>	[1.032,1.090]	1.062 <sup>***</sup>	[1.037,1.088]	1.040 <sup>***</sup>	[1.018,1.063]	1.007	[0.984,1.031]
<i>N</i>	450		450		450		450	

\*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$ . IRR: incidence rate ratio (values above 1 indicate a positive effect; values below 1 indicate a negative effect. In both cases, the significance (or otherwise) is shown by stars).

### 6.3.2 Childhood obesity

Childhood obesity was explored through first and second phase fieldwork, national surveys of DPH and CCG members of HWBs, documentary analysis and through a quantitative analysis of spend and outcome.

Participation in the NCMP is a mandatory function and reported as a separate category of the public health ring-fenced budget. Surveys (n=39 (2015) and 36 (2016)) showed that funding for the NCMP from the public health budget was considered adequate by four-fifths of respondents in each case. There was some criticism of the NCMP, which had sometimes created a backlash among parents and a follow-up programme was not always available. A majority of survey respondents (2016) considered that funding was inadequate for exercise schemes (52%) and services to address obesity in children (68%).

Spend on childhood obesity was described as 'difficult to categorise': it did not fit neatly into the public health budget reporting categories, given spend on children across directorates and the importance of cross-directorate approaches. Programmes were sometimes delivered through children's centres (not necessarily funded through the public health grant) and there were links to physical activity programmes in schools and elsewhere, as well as breast-feeding initiatives.

#### ***Approaches adopted in case study sites***

Childhood obesity was recognised as a major problem. In the 12 months since first phase fieldwork, four sites had reviewed their strategy for tackling childhood obesity, (more often referred to as 'healthy weight'), or were in the process of doing so. All DsPH spoke of having a strategy, although in some sites the strategy was integrated into the JHWS rather than being a stand-alone document or was part of a wider obesity strategy. Interviewees also spoke of strategies being reviewed alongside strategies for Children and Young People, nutrition or physical activity, with the aim of better integration of services. This reflected recognition of the public health responsibility of the local authority as a whole and not just of the public health workforce transferred to local government.

Where there were separate strategies for healthy eating, obesity and physical activity, there were examples of bringing contracts together on a population basis rather than just for children. A DPH (Phase 2) noted:

*We're trying to integrate healthy eating, obesity, childhood obesity, physical activity strategies because we don't think they should be dealt with separately as two different things, you know, for the whole population, which includes children.*

Some interviewees spoke of having support and leadership from Elected Members and the Chief Executive to achieve this. In one site, an Elected Member noted:

*I made sure when we made our pledges for the ward that I represent that they included health issues and, you know, childhood obesity in particular is an issue in my ward. So that's one of our pledges. So when we're having days of action or a stall around different councillor services, I make sure we've got a lot of stuff going for health.*

There were attempts to implement a whole system approach to obesity and to integrate initiatives within children's services or on a family/community basis. These are discussed in turn.

### *System-wide approaches*

In some sites, childhood obesity had been addressed through initiatives including: restricting planning applications for fast food outlets within a certain distance of schools; providing sports and exercise facilities and working through sporting networks; working with housing trusts to provide play spaces; and working with local retailers and employers to address the wider environment promoting sugar consumption. One site had achieved national recognition for reducing sugar consumption and another in developing system-wide approaches. In other sites, however, there was little evidence of cross-directorate action.

Tensions between the benefits of income generation and the disbenefits of both fast food outlets and vending machines in schools had hampered developments in some sites, but in one case it was noted that discussions were now taking place on the 'place aspect' of people's health as a result of the reforms.

### *Integration with children's services*

A major benefit of the reforms in relation to encouraging healthy weight was the closer relationship between public health teams and local schools, although schools showed different levels of engagement. Healthy schools initiatives and programmes were widespread, ranging from 'healthy eating' school meals services to childhood obesity programmes supported through school nursing. In some cases, childhood obesity services had been re-commissioned to be delivered through school nursing.

The transfer of children's services and the implementation of new and more integrated services (0-19) from April 2017 were described as providing further opportunities to integrate healthy nutrition as part of school activities and through children's services more generally.

A DPH noted:

*But it will also be in the KPIs<sup>9</sup> for the wider children's joint commissioning, so there's a big role for health visitors certainly and for other services. So childhood obesity will be in their KPIs and we'll have to work to make sure that the two services work seamlessly together. It's always difficult to tease that one out.*

Second phase interviewees also emphasised this shift from dedicated weight management services for children towards integration with children's services.

Interviewees highlighted numerous initiatives (see Box 7) for examples.

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<sup>9</sup> Key Performance Indicator

#### Box 7: Childhood obesity interventions highlighted by interviewees

- Regular meetings between public health teams and head teachers;
- Working across early years providers on play strategies;
- Using children’s centres as a vehicle for delivering public health programmes, including those for healthy weight and exercise;
- CCG funding the VCSE sector to deliver a school-based obesity prevention and programmes around healthy food choices;
- Growing, cooking and eating healthy food in schools and with families;
- ‘Food for Life’ (Soil Association) in selected primary schools, with a ‘whole school’ approach to healthy eating and nutrition;
- Revising healthy schools programme and building in action on childhood obesity;
- A flexible approach to engaging with families, not limited to education or public health professionals, building on established relationships and reflecting a multi-agency approach;
- Family rather than clinic-based interventions, working through leisure centres (including referral following the NCMP);
- School nurses commissioned to provide weight management services;
- Sugar campaign in schools and a series of ‘sugar debates’;
- Changing the school meals service contract in order to comply with sugar reduction objectives;
- Walk to school initiatives – across all ages.

VCSE sector interviewees in three sites were involved specifically in engaging underserved groups in this area, working with parents and communities as well as individual children. One interviewee spoke of a range of services, delivered through a contract with a consortium of VCSE sector organisations. However, delivery of the service was dependent on referrals from the school nursing service. In one example, the school nursing service was being provided through a contract awarded to a private sector organisation, and there was currently a ‘block’:

*The school nurses aren’t doing that (i.e. referring) terribly effectively, and we’re being told that they don’t have time to do it and we’re not getting the referrals through in the numbers that we should be.*

As described in section 6.2, there was a shift away from clinic services towards services centred on the family and community. This was emphasised further in second phase interviews. A DPH noted:

*For weight management, we’re moving away from a traditional clinic dietician-based service to one that’s much more family, community-based for this very reason, recognising the importance of the family in influencing children’s health and wellbeing and development.*

#### **Problems in implementation**

Interviewees raised questions about the effectiveness of local action on childhood obesity, partly because the evidence base for interventions was not considered strong and partly because much depended on action at a national level.

Obesity was often raised as an example where the evidence base for public health interventions was weak. One interviewee asked:

*Do these programmes ... make any difference at all? Is there any significance? And it's quite interesting that so far, as was shared with us yesterday, there's no positive outcome data for obesity strategies and yet there's a proliferation of them and an enormous amount of public money spent and I think it highlighted, if you like, some of the cultural differences.*

This was reflected in other sites. A DPH (Phase 2) commented:

*We did a systematic review of evidence of dedicated interventions and found that there was nothing useful to do that we could afford. So we've reverted instead to pushing other methodologies and universal services rather than commissioning specific services because ... the evidence base for intervention in childhood obesity is really quite weak, and the interventions that do have an effect, the effect wears off every 14 months or so, so you'd have to keep repeating the intervention over and over again.*

This had implications for how far such programmes were prioritised, as one interviewee commented:

*In the local authority we would spend money if we could evidence it had a positive outcome. I think sometimes within the health agenda, spending money is an acknowledgement that the problem has been seen rather than necessarily being able to resolve the problem.*

Even where evidence was available, proposals would be assessed against other council priorities or in relation to mandated public health services. A HWB Chair reflected that there 'wasn't an awful lot left for healthy weight' following the procurement of mandated services.

Other interviewees emphasised the limitations of local level action and the need for national action on planning regulations for fast food outlets and reducing sugar consumption. Planning decisions related to restriction of fast food outlets were often overturned on appeal, despite Member support. An Elected Member (Phase 2) noted:

*I mean with obviously the national policy agenda, if you could even call it that, around childhood obesity being so weak, you don't feel very encouraged actually.*

One case study site adopted a proactive approach, funding three independent lobbying and advocacy organisations 'to undertake challenges to multinational companies with interests in promoting unhealthy products to children'.

### **A national overview**

Our two national surveys of DPH and CCG members of HWBs provided more detailed information about services for childhood obesity, although the small number of respondents limits generalisability of findings. When comparing results in 2015 and 2016 (n=39 (2015) and 36 (2016)), there was an increase in respondents considering that initiatives to address childhood obesity were being encouraged across directorates (from 64% in 2015 to 72% in 2016). These results were reflected in specific questions related to initiatives for childhood obesity, with increases in the percentage of respondents indicating funded initiatives in the following areas: using the planning system to regulate fast food outlets around schools (from 26% to 39%); active travel (from 33% to 53%); and promoting use of green space (from 44%

to 67%). There was a smaller increase in the percentages of those considering that more lifestyle management services were being provided through the local authority (from 26% to 33%).

In their comments, survey respondents included 20mph speed limits, cycle to school/walking strategies, exclusion zones for fast food outlets, and school-based initiatives. Unsurprisingly, it was noted that many of these initiatives predated the reforms.

In both surveys, most respondents reported no increase in initiatives to prevent childhood obesity, lifestyle-related weight management services, new providers or investment in healthy eating initiatives. Family and school-based interventions were more prominent than advice, reflecting the views of interviewees in case study sites.

A question on providers of services for childhood obesity (Table 10) shows that, in some cases, lifestyle services were not provided (and this was more often the case for healthy eating and exercise schemes in 2016) and there was little change in the percentage of respondents citing school-related services. Overall, NHS Trusts were cited most frequently as providers of combined lifestyle management services and weight loss services. VCSE sector organisations were most frequently cited as providing healthy eating initiatives and exercise schemes. Pharmacists and GP practices were the least frequently reported as providers of combined lifestyle management, healthy eating and exercise schemes. Volunteers were mentioned as providers of all types of services in 2016, although written comments suggested that some respondents did not find it easy to differentiate between 'VCSE organisations', which can include organisations using volunteers to provide services, and 'volunteers'. Consequently, it is unclear whether these responses refer to volunteers who are recruited and managed by a VCSE organisation, volunteers who are recruited and managed by a statutory organisation, or volunteers who operate independently (for example, some services delivered through a community assets approach). Respondents commented on topics, including the failure to continue the national Healthy Schools Programme, how health trainers had been decommissioned in order to fund weight management programmes and the importance of providing nutrition advice in child care settings.

**Table 10: Who provided services for preventing childhood obesity and helping overweight children and young people?** (Note: respondents ticked all that applied)

	Combined lifestyle management services		Healthy eating initiatives		Exercise schemes		Weight loss services	
	2015	2016	2015	2016	2015	2016	2015	2016
Not provided	21%	20%	3%	9%	3%	11%	18%	15%
VCSE organisations	12%	34%	29%	50%	26%	49%	21%	29%
Don't know	12%	6%	15%	3%	9%	3%	9%	6%
Private providers	6%	9%	12%	15%	15%	20%	18%	21%
LA primary school nursing service	30%	31%	32%	38%	32%	23%	21%	18%
GP practices	15%	11%	12%	12%	12%	11%	12%	18%
LA secondary school nursing service	21%	23%	21%	29%	21%	20%	12%	15%
LA (other)	.	.	.	.	.	.	.	.
NHS Trusts	30%	37%	21%	38%	21%	31%	26%	53%
Pharmacists	6%	3%	6%	6%	6%	.	6%	.
Volunteers	.	6%	6%	12%	6%	11%	3%	6%
Number of respondents (N)	33	35	34	34	34	35	34	34

**Note:** Response rates for the surveys were low and this prevents generalisation of results. For survey one, there were 39 responses (11 CCG members of HWBs (response rate: 7.2%, 11/152) and 28 DsPH (20.7%, 28/135)). For survey 2, there were 36 responses including 6 CCG members of HWBs (response rate 4%, 6/152) and 30 DsPH/ other public health representatives (response rate 23%, 30/133)).

### ***Documentary analysis***

Analysis was undertaken on documents referred to by interviewees when questioned about approaches to tackling obesity, including childhood obesity, and documents/web pages identified through searches of case study site web pages. Web page word searches used terms and variants on 'weight' and 'obesity', with snowballing to associated pages, including pages hosted by external organisations.

Only five case study sites published a strategy document associated with obesity or achieving healthy weight, although some integrated strategies for healthy weight in wider strategies. Strategies included whole system approaches, family-based strategies for children, play strategies and licensing restrictions, sometimes under the banner of wider partnerships spanning the NHS, local authority and others. Not all strategies were available on council websites and action arising from the strategies was not easy to identify.

### ***Approach***

Services were provided to the general population. Tailored support was also offered to children and young people, pregnant women, adults with disabilities, and other adults who were judged to be in need of additional support because of their unhealthy weight. Most, but not all, sites provided an integrated weight management service for those identified as needing specialist support. The approach of most sites was to promote 'healthy lifestyles', combining healthy eating and active lifestyles.

### ***Services and support offered***

Case study sites offered a range of services and support to achieve healthy weight/obesity reduction priorities, summarised in Box 8.

#### **Box 8: Support for achieving healthy weight (documentary analysis)**

- **Specialist advisors:** One site had a specialist team providing advice to schools on strategies to support achievement of healthy weight.
- **Information, advice and web-based tools:** Half of the case study sites provided information on free advice and signposting to other sources of advice or on-line tools to encourage healthy lifestyles and weight reduction. These included links to the NHS Choices website, Weight Watchers and the Change4Life programme. One rural site expanded this service to include 1:1 telephone based support, coaching and advice. It also provided tailored self-help and signposting to self-funded and free community based opportunities. This represented the first tier of the site's integrated weight management service.
- **Food Nudge:** Three sites took action to make it easier for people to eat healthily or to consider the impact of eating a poor diet. One had adopted a policy of serving healthier food in all public sector settings (e.g. council-owned residential or day centres, council meetings), and of providing economic incentives for healthier food businesses. The second site had reduced sugar in school meals, and organised a series of debates in schools to encourage children and young people to consider the impact of sugar on diet. The third site adopted a restrictive planning policy in relation to hot food takeaways as part of its Local Plan. As a consequence, five fast food takeaway applications were refused in 2015/16.
- **Exercise Nudge:** Sites had taken action to make it easier for people to build exercise and increased physical activity into their daily life. One offered encouragement through a reduction on the cost of leisure services to people in receipt of certain benefits or over the age of 75. Others adopted an open access strategy, such as increasing CCTV in public spaces so people felt



safe to use them, increasing the level of high quality green space, and by providing free park facilities such as outdoor gyms or table tennis and events such as dancing or walks. Two sites targeted children and young people, such as through developing its 'safe routes to school' programme or using play rangers to encourage healthy lifestyles through exercise and healthy eating.

- **Volunteers and peer mentors:** Two sites used volunteers and peer mentors as part of their strategy. One site used volunteer Health Champions as a link between people in need of support and 'weight management care pathways'. The second used volunteer Youth Champions to increase accessibility of health services for young people.
- **Exercise programmes:** Three sites provided exercise programmes specifically linked with reducing obesity and achieving a healthy weight. One provided a programme of activities for adults with a disability. The second provided 1.5 hour group sessions focused on increasing motivation and circuit-based exercise for people identified as needing additional support to achieve a healthy weight. The third site offered a week-long intensive dance programme for 7-13 year olds who do not access dance/physical activity and/or are above a healthy weight. Two sites reported introducing the 'daily mile' programme, encouraging children and young people to run one mile each day as part of the school routine.
- **Diet programmes:** One site provided diet-only support to people identified as needing additional support. In this site, people may be referred by their GP to a dietician, and/or may have free attendance at Weight Watchers.
- **Integrated weight management service:** Most sites provided an integrated weight management service for those identified as needing additional support to achieve a healthy weight. These involved a range of providers and combined tailored advice, exercise and diet programmes for individuals identified as needing additional support to achieve a healthy weight. Of these, three sites provided a service for adults only, two sites provided a service for children and young people only, and one site offered integrated services to both adults and to children and young people. The services for children and young people took a family and community-based approach. One of these offered age-specific programmes, ranging from children aged 2-4 to young people in their teens. This service also offered support to post-natal women.

#### *Time scales*

Not all sites gave details of the periods over which services would be available to those needing additional support. Of those which did, the time scale for achieving a change in lifestyle and/or reducing weight ranged from 1 week (intensive dance programme) to 24 months (tailored support from a multi-skilled team) with a number of sites offering 12 weeks' support (Tier 2) with further support available. Free use of leisure facilities was offered in some sites.

#### *Referral processes*

Of those sites which provided information on how to access these services, three enabled self-referrals by adults for assessment by integrated weight management service professionals, while others required referral via GPs or other health professionals. Services for children and young people were only available through referral by GPs or other health professionals. One Children and Young People's service was only available to those living in one area of the local authority, and had been closed to new referrals, although existing families continued to be supported.

#### *Charges and sponsorship*

There was a combination of free and self-funded services and the balance varied across sites. Some had continued to provide free leisure services for certain groups while others had moved towards self-funding for services, such as those from Slimming World. One site was able to provide free services, rather than charge for them, because of sponsorship from an external body.

### Measures, targets and performance

As stated above, only half the case study sites had a specific strategy to address obesity or unhealthy weight. This review found little documentation on measures, targets and performance. It was difficult to identify changes in policy or strategies over time as documents were not regularly updated.

### Analysis of spend and outcome

#### Introduction

As part of the tendering process, the DH asked us to quantify the relationship between spend and outcomes. To address this in the case of childhood obesity, we examined the impact of three categories of expenditure: obesity (in children), physical activity (in children) and the Children's 5-19 Public Health Programme.

Figure 4 shows trends in childhood obesity, measured as the proportion of children who are overweight or obese. The figure uses aggregated NCMP data for England, and includes the period 2006/07 to 2012/13 when the NHS was responsible for commissioning the programme. In Figure 5, trends are reported by local authority class (type). At the start of primary school, variation between class of local authority is small, but distinctions have emerged by year 6 (i.e. children aged 10-11).

The geographical variation in patterns of childhood obesity is shown in Figure 6. Figure 7 shows how spend in 2013/14 varies against outcomes in 2015/16, when plotted by level of deprivation. These show the unadjusted data (i.e. before controlling for other factors affecting outcomes).

Figure 4: National trends in childhood obesity: reception (aged 4-5) and year 6 (aged 10-11)

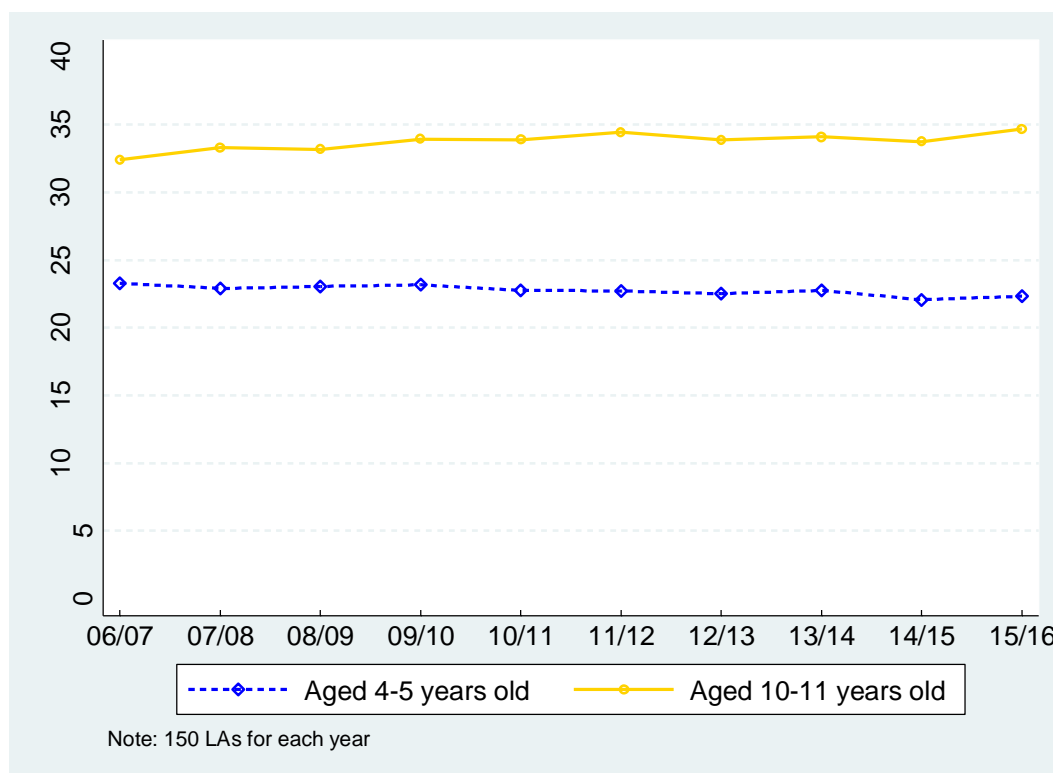


Figure 5: Trends in childhood obesity by LA class (type): by school year

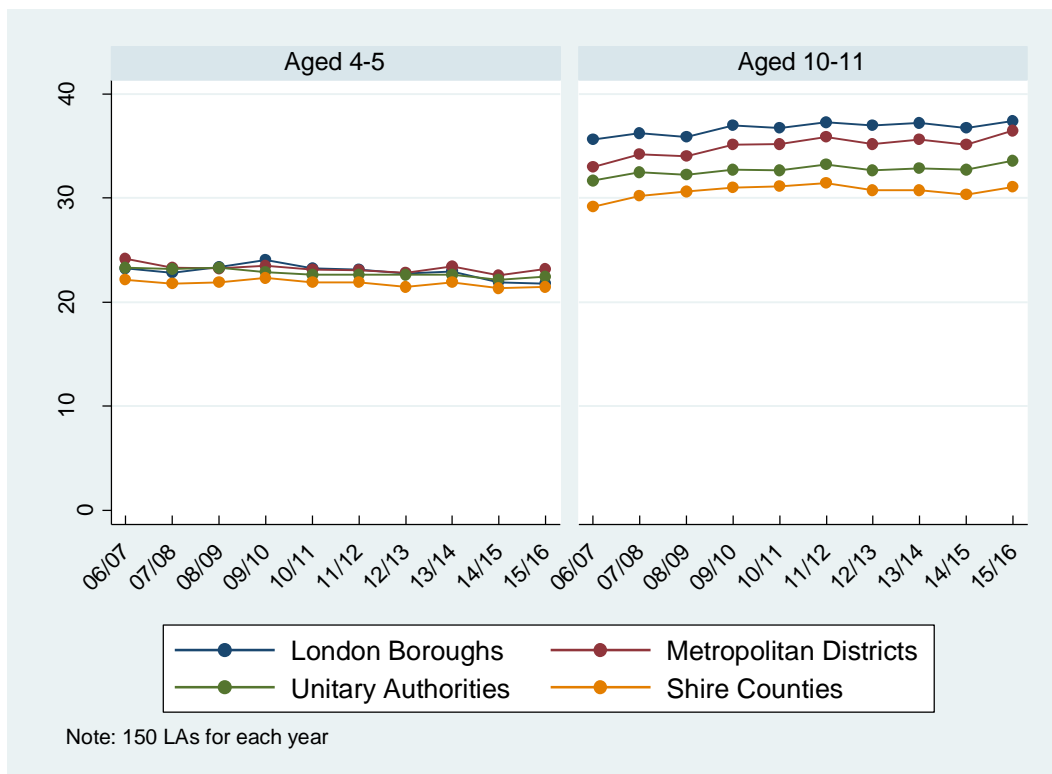


Figure 6: The prevalence of overweight and obesity for children aged 4 to 5 (left) and aged 10 to 11 (right) at the upper tier LA level in England (2015/16)

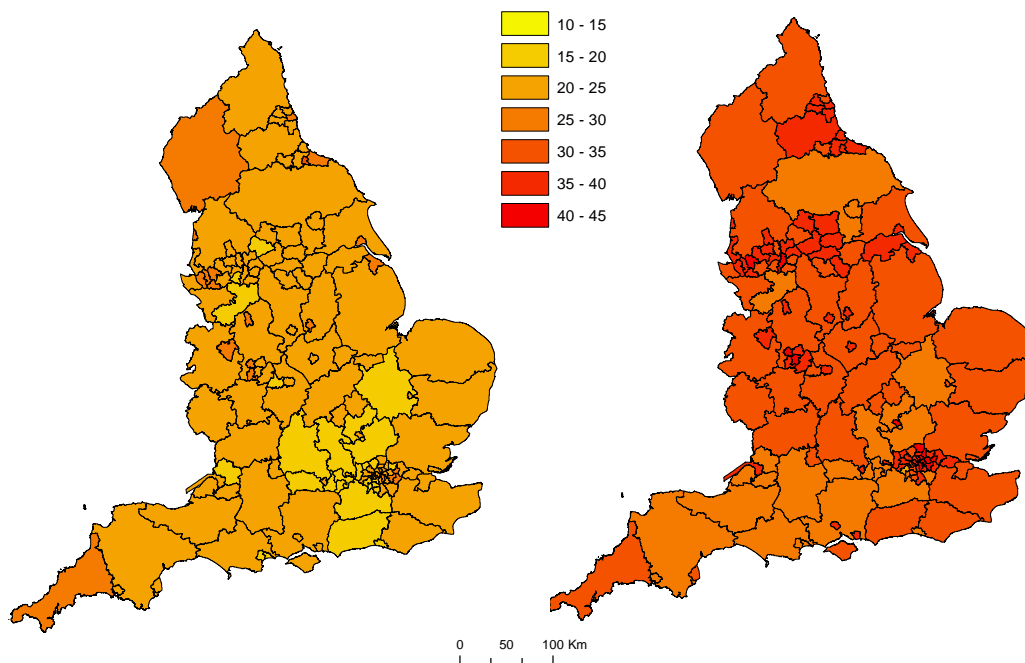
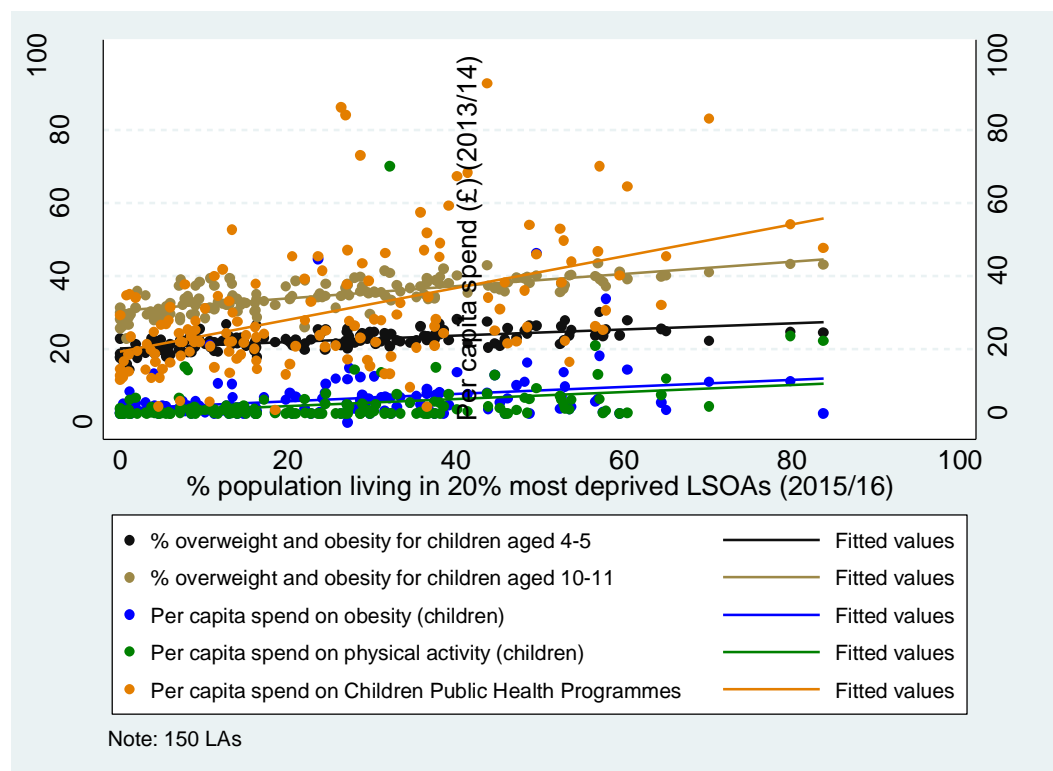


Figure 7: Relationship between outcomes, spend on childhood obesity, and deprivation



### Methods

The study sought to identify the effects of three measures of local authority expenditure on childhood obesity. As the aim was to identify causal relationships, we used measures of spend in 2013/14 to explain outcomes in 2015/16 (the latest year available). However, with just three years of data to capture the period since the inception of local authority commissioning of public health, robust inferences regarding the nature of the relationship between spend and outcomes are not possible.

The principal data source for the outcome variable - defined as the proportion of children within the local authority who were overweight or obese - was the NCMP, which covers school children in Reception year (aged 4 to 5) and Year 6 (age 10 to 11). We used the aggregated data at local authority level.

Spend on childhood obesity in earlier years was the principal explanatory variable, and utilised local authority revenue returns data. The model also included local authority spend on children's physical activity, and on the public health children's programme. Per capita values were derived by dividing local authority net current expenditure by the number of children aged 5-19 in each local authority.

In the base case, we used terciles of per capita expenditure for 2013/14, i.e. low, medium and high categories. In the sensitivity analyses, we also tested:

1. Per capita spend in 2013/14;
2. Mean expenditure across 2013/14 and 2014/15;
3. The sum of: childhood obesity, physical activity, and the children's Public Health programme, as a percentage of total public health spend.

We reviewed the literature on non-interventional factors predicting childhood obesity to inform the selection of control variables. These comprised: local authority class (type);

rurality and deprivation; the proportion of children from minority ethnic groups; and the number of fast-food outlets per 100,000 persons. We also adjusted for age and gender characteristics of the local authority population. The proportion of non-white primary school children was sourced from National Statistics,<sup>10</sup> and PHE publishes data on local density of fast-food outlets.<sup>11</sup>

### Results

Over the three years, local authority spend on childhood obesity averaged £4.75 per child (5 to 19), equivalent to 1.2% of total spend on public health. Corresponding figures for children's physical activity were £3.59 (1.0%) with an average of £29.91 spent annually on over 5s on the Children's 5-19 Public Health Programme (9.2% of total public health spend). There was considerable variation in these statistics, both across local authorities and over time.

In the base case analysis, none of the measures of local authority spend in 2013/14 was significantly associated with the proportion of obese or overweight children (Table 11).

In each of the age groups, local authority levels of childhood obesity in 2015/16 were significantly and positively associated with obesity levels in 2013/14. As these four cohorts comprise entirely different pupils, this provides confirmatory evidence of geographical drivers of childhood obesity (see Figure 6). Higher levels of local authority deprivation were associated with higher levels of obesity, and local authorities with higher levels of minority ethnic children had significantly lower levels of obesity in the younger age group (only).

**Table 11: Results from the base case regression analyses of childhood obesity**

	Aged 4 to 5		Aged 10 to 11	
	IRR	95% CI	IRR	95% CI
<b>Terciles of per capita spend, 2013/14</b>				
Childhood obesity: medium	0.989	[0.960,1.018]	1.000	[0.982,1.018]
Childhood obesity: high	1.002	[0.976,1.029]	1.007	[0.987,1.028]
Children's physical activity: medium	1.021	[0.995,1.048]	1.005	[0.987,1.024]
Children's physical activity: high	1.010	[0.976,1.046]	1.015	[0.997,1.034]
Children Public Health Programme: medium	1.004	[0.977,1.032]	1.005	[0.988,1.023]
Children Public Health Programme: high	1.008	[0.978,1.038]	1.003	[0.983,1.024]
2013: % Children aged 4-5 overweight and obese	1.025 <sup>***</sup>	[1.019,1.031]		
2013: % Children aged 10-11 overweight and obese			1.026 <sup>***</sup>	[1.022,1.029]
Percentage of males aged 4-5 years old	1.008	[0.990,1.026]		
Percentage of males aged 10-11 years old			1.000	[0.990,1.011]
% LA rural pop (incl. hub towns), 2011	1.000	[0.999,1.001]	1.000	[1.000,1.000]
% living in 20% most deprived LSOAs	1.003 <sup>***</sup>	[1.002,1.004]	1.001 <sup>*</sup>	[1.000,1.001]

<sup>10</sup> <https://www.gov.uk/government/collections/statistics-school-and-pupil-numbers>

<sup>11</sup> <https://www.noo.org.uk/visualisation>

% Minority ethnicity	0.999**	[0.998,1.000]	1.000	[1.000,1.001]
Fast food outlets per 100,000 population	1.000	[1.000,1.001]	1.000	[1.000,1.001]
Class: London Boroughs	1.000	[0.955,1.046]	0.981	[0.950,1.014]
Class: Metropolitan Districts	0.979	[0.952,1.008]	0.994	[0.974,1.014]
Class: Shire Counties	1.002	[0.965,1.040]	0.998	[0.980,1.017]
Observations	150		150	

Note: Exponentiated coefficients from negative binomial model; \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$ . All variables are for 2015/16, unless stated otherwise. IRR: incidence rate ratios (values above 1 indicate a positive effect, values below 1 show a negative effect).

The sensitivity analyses tested whether the relationship between spend and outcomes depended on how local authority spend was measured. Findings are summarised in Table 12. When per capita spend was entered in the model as a continuous variable, spend on children's physical activity (2013/14) was positively related to childhood obesity in 2015/16. A similar relationship was evident in the model that captured local authority expenditure using total spend on children measured as a proportion of total public health spend. None of the other measures of spend was significantly related to levels of childhood obesity.

**Table 12: Results from the sensitivity analyses of childhood obesity**

	Aged 4 to 5		Aged 10 to 11	
	IRR	95% CI	IRR	95% CI
<b>Per capita spend 2013/14</b>				
Childhood obesity	1.001	[1.000,1.003]	1.000	[0.998,1.001]
Children's physical activity	0.999	[0.998,1.000]	1.001***	[1.001,1.002]
Children Public Health Programme	1.000	[0.999,1.001]	1.000	[1.000,1.001]
<b>Terciles of mean per capita spend 2013/14 to 2014/15</b>				
Childhood obesity: medium	1.009	[0.985,1.033]	1.000	[0.984,1.017]
Childhood obesity: high	1.006	[0.982,1.031]	0.995	[0.976,1.015]
Children's physical activity: medium	1.012	[0.991,1.033]	0.999	[0.984,1.014]
Children's physical activity: high	0.998	[0.972,1.024]	1.009	[0.992,1.026]
Children Public Health Programme: medium	0.999	[0.975,1.024]	1.000	[0.984,1.015]
Children Public Health Programme: high	1.012	[0.986,1.039]	1.003	[0.983,1.025]
<b>Percentage of total PH spend, 2013/14</b>				
child obesity + physical activity + PH programme	1.001	[0.999,1.003]	1.002*	[1.000,1.003]

Note: Exponentiated coefficients from negative binomial model; \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$ . IRR: incidence rate ratios (values above 1 indicate a positive effect, values below 1 show a negative effect).

Identifying the influence of spend on outcome is complex due to the wide range of factors influencing childhood obesity. While the study showed wide variation in the approaches adopted across sites, there was evidence of greater integration with strategies for children and young people, with schools and with children's services, including school nursing. Action was being taken across directorates, for example, in relation to planning restrictions, and through working with local retailers. Limitations included a weak public health evidence base, data deficiencies and the need for concurrent national action.

Impacts will always be longer term and attribution will always be challenging but there is a need for robust research to try to identify how limited resources can be best used to tackle upward trends in obesity, increasing multi-morbidity and health inequalities.

## **6.4 Influencing and commissioning across a public health system**

### **6.4.1 Introduction**

Greater influence over wider determinants of health was a key rationale for the transfer of public health responsibilities to local authorities. It was considered both the main advantage of the reforms by interviewees and as one of the hallmarks of public health leadership, given that a system-wide approach is recognised as key to addressing complex, multi-factorial public health problems. As discussed in previous sections, improving public health outcomes goes beyond commissioning specific preventive services or deploying a public health budget. It requires, as a minimum, a degree of collaboration across local authority directorates and across local authorities and the NHS, and as a maximum, leadership and coordinated action across partners across a whole system.

This section considers the impact of the reforms on commissioning across a public health system, drawing on first and second phase fieldwork and results of the two national surveys of DPH and CCG members of HWBs. Interviewees were asked questions related to leadership across the local system, collaboration across CCGs and local authorities, communication for health protection and for data sharing, the impact of the PHOF and the role of the NHS. They were also asked to identify enablers and barriers for improving the public health system. Surveys reflected these questions, allowing for comparison with interview data.

This section begins by discussing public health challenges identified by interviewees (6.4.2) and the cross-directorate working and system-wide approaches required to address them (6.4.3). It considers the public health role of District Councils (6.4.4) and shows how public health reforms had promoted collaboration in some areas but had led to a degree of fragmentation in others (6.4.5). The impact of STPs is discussed (6.4.6) and the section concludes with views of enablers and barriers to commissioning across the system (6.4.7).

### **6.4.2 Public health challenges**

Interviewees highlighted challenges related to: deprivation, premature mortality and health inequalities; risks associated with obesity and particularly the long-term impact of childhood obesity; and long-standing problems associated with smoking, alcohol and drug misuse. Infections, such as TB, and the late diagnosis of HIV were a cause for concern and mental health problems, particularly among young people, were often cited. Interviewees also highlighted challenges arising from social isolation, domestic violence, crime and violence, needs of migrants, homelessness, lack of readiness for school and troubled families, reflecting broader social perspectives on what constitutes a public health problem.

### **6.4.3 System-wide approaches for specific public health challenges**

Interviewees described a wide range of partnerships aimed at improving health-related outcomes, although many such initiatives were well-established and not related to the reforms. Initiatives could be focused on health aspects of specific services (such as for domestic violence) or involve collaboration over single public health-related issues, ranging from smoke-free public places to regulation of shisha bars (working with police and the VCSE sector), or reducing fat and salt in produce (working with local retailers). Case study sites were also involved in wider strategic partnerships across county and district authorities. A DPH described their involvement in a strategic partnership where:

*the mantra of [partnership name] is that economic wellbeing and health and wellbeing are two sides of the same coin ... .The solutions to those problems are through economic growth that [partnership name] will be supporting leading, championing and so on.*

This section discusses how public health priorities were being reflected within and across directorates and across wider partnerships.

### ***Public health priorities reflected within and across directorates***

Embedding a public health perspective within and across directorates, including housing, planning, licensing, income support, employment and environment, was a key aspect of the reforms. This could be promoted through: greater influence of public health teams within directorates; routine use of health and health inequalities impact assessment; breadth of HWB membership and debate; and, for multi-district authorities, coordination across districts and county councils. These are discussed in turn.

### ***Involvement and influence of public health teams across directorates***

It was recognised that public health involvement within specific directorates could encourage greater recognition of public health impact across the range of services. Cross-directorate working had reportedly led to measurable improvements in commissioning in some sites. One DPH (Phase 2) spoke of public health involvement as strengthening the evidence base, leading to other directorates commissioning services to address public health objectives. A director responsible for adult social care in another site also spoke of a shared and strengthened evidence base and a commitment to shared commissioning, resulting in a position whereby 'the money works as a whole much more efficiently and effectively'. There was a broader advocacy and strategic role for public health teams, and public health representatives were increasingly involved in planning groups across directorates. In one site, the public health team was involved in planning groups for addressing smoke-free public places and, in another, in promoting 'green parks and spaces' within leisure services. In this example, the public health team also hosted monthly cross-council public health forums to discuss topics with opportunities for partnership delivery, such as for dementia services or sugar reduction.

Second phase fieldwork showed that cross-directorate working had increased with public health more embedded in other service areas. Networking skills of public health teams and the ability to communicate across service boundaries and hierarchies, including the ability to build positive relationships with Elected Members, continued to be an important enabler. Most DsPH reported improvements in this area, but some felt frustrated by council structures and cultures which they believed prevented them from making progress.

Nevertheless, sites varied in how cross-directorate working was interpreted, implemented and coordinated. Involvement of public health staff in directorates for adult and children's services was common in both first and second phase fieldwork, but there was less evidence of involvement in highways, environmental services, planning or regeneration. Local government was described by one Elected Member as a 'slow moving beast' in this respect. However, some sites described 'acceleration' of cross-directorate working, with an influence over local authority strategies and plans which had not been possible previously, even where DsPH were joint appointments. There were close links with culture and leisure services across a number of sites, with the DPH holding the budget for leisure services in two sites and further examples of grant applications supported by public health teams, bringing



together leisure and public health. In another site, an internal 'public health board' had been set up, where all the main directorates of the council were represented. This was described as a 'sort of oversight governance around the public health function and budget' enabling 'cross-council officer discussion'. This had resulted in closer involvement of the public health team in the directorate for growth and regeneration. In addition to this, there was a HWB programme board, broader than the HWB, chaired by an Executive Director, and incorporating 'movers and shakers' across the authority.

In one site, a systematic approach had been adopted to reflect and build on the authority as a 'public health council', including all directorates and the support of Elected Members and not limited to the use of the public health budget. The public health budget (via a 'social determinants of health fund') was used as a catalyst for other directorates, with regular reporting on targets, as agreed in a public health delivery agreement. This fund had two aspects. First, each directorate was asked to provide specific public health services (sometimes funded through the public health budget as a pump-priming mechanism, and sometimes through negotiation as part of its mainstream provision). This was described by the DPH as a way to 'stimulate the thinking within the department, almost buying public health outcomes from them on a performance basis'. Second, directorates drew on their own mainstream budgets to contribute to extra outcomes in the PHOF, thus promoting the mainstreaming of public health outcomes within local government performance. This was reflected in a formal delivery agreement with each directorate, performance monitoring of public health outcomes and engagement of Elected Members through regular reporting by each portfolio holder to the senior policy team so that 'responsibility and outcomes come back to every portfolio holder' (HWB Chair). The DPH emphasised that the 'culture of other social systems' needed to change so that health was generated as an added value.

As in other sites, existing public health-related activity across the council which was under threat from cuts was supported by the public health budget.

Barriers to cross-directorate action derived from outsourcing of services, such as education and housing, and the risk of local planning decisions on fast food outlets, for example, being overturned on appeal. While many issues needed changes in national policy, one Healthwatch interviewee emphasised the importance of local influence, and the need to 'build up an agenda locally that can influence nationally'. Other barriers could include a belief on the part of some Elected Members that health services had a greater influence on public health than wider determinants. In addition, scrutiny of cross-directorate working was limited and made complicated by the fact that different Scrutiny Communities could be involved and it was not clear where cross-directorate approaches, *per se*, were considered (further discussed in section 6.6.6).

While national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) showed a slight decrease (from 87% in 2015 to 75% in 2016) in respondents agreeing that public health concerns were being integrated into local authority directorates, this still represents a large majority. Two DsPH (Survey 1) highlighted *integrated approaches across local authority directorates*, including the use of HIA, Health Equity Assessment (HEA) and SROI to influence decision-making. A DPH respondent noted that:

*Improved joint working between directorates is supporting this. Public Health is involved in many areas of council working - fuel poverty, employment, housing and homelessness, improving care home provision, children's services development.*

### *Health and health equity impact assessment*

The use of HIA has been recognised as a tool for embedding public health into local government decision-making. In two sites, it was already being carried out, and one interviewee cited a public health impact statement on 'everything that goes through cabinet'. A further DPH commented:

*And that's, sort of, an example of where we started really, about what are the benefits of working within the council, that we do now have a health impact assessment process as part of that planning process and also our licensing processes.*

In another site, health equity impact for all local authority policies was being considered. A DPH described the change as follows:

*We can challenge other directorates on what they're doing on social care, children and education, and, by the way, what has that done for inequalities? Because that's not been on their checklist hitherto.*

However, it was also argued that routine requirement for equity impact could turn into a 'tick box' exercise, so much depended on how it was carried out. The national surveys of DPH and CCG members of HWBs showed that 53% considered that HIAs were being developed in 2016, compared with 41% in 2015, although numbers are small.

### ***Working across partners***

Most strategies involved partnerships, reflected through HWBs, joint commissioning groups and multi-agency partnerships for particular issues, such as obesity or alcohol. Surveys showed a small increase (from 77% to 84%) in respondents considering that multi-agency approaches to support healthy lifestyles were being developed.

While first phase interviewees focused on the role of the HWB, second phase interviews took place when 44 STPs had been established. There were reports of JSNAs and JHWSs informing and being closely aligned with STPs, consequently enabling successful commissioning across a wider system. Questions related to STPs were included in second phase interviews and views over their development are discussed separately (6.4.6).

### *The role of JSNAs and HWBs*

To some degree, commitment to a cross-directorate and wider partnership approach was reflected in the breadth of HWB membership and the extent to which wider public health issues were discussed and reflected in JSNAs and JHWSs.

While a broader and cross-directorate approach to developing the JSNA was implied by the nature of public health challenges, some interviewees criticised the JSNA for its narrowness, its lack of focus on education or social care, for example, and its emphasis on needs rather than assets. It was argued that where public health teams were better integrated into an authority-wide commissioning team, the JSNA could help underpin commissioning decisions more widely across directorates and also promote cross-directorate working. Other directorates had been encouraged to 'own' the JSNA, for example, including issues such as child sexual exploitation and the needs of children in care. An Executive Director noted:

*And, you know, in terms of the work within our directorate, the public health perspective and narrative and information data is helping to underpin some of those commissioning decisions, which is really good.*

The benefits of bringing 'academic research thinking into a more localised place', were highlighted, along with the benefits of contributing a research perspective in a context where local authority officers were more 'operationally focused'.

In second phase fieldwork, there were reports of the scope of JHWSs being broadened. In one site, the HWB Chair noted the shift in the new strategy from 'a very specific issue-based plan to one that's much broader about the greater needs of the population' and the DPH (Phase 2) noted:

*So this time, it's much broader. We have a lot of consultation with it and although we were trying to keep it fairly tight, our public told us that they wanted all of these things included. So we've got a very broad health lobbying strategy and we use that as the vehicle for working with the wider partnership and the wider council on those universal services.*

HWBs provided one route for aligning strategies and priorities across partners but varied in their breadth of membership. In one site, in addition to statutory membership, the HWB included representatives from the VCSE sector, police, housing, the crime and drugs partnership and NHS providers. Greater emphasis was often placed on the integration of health and social care, where the Better Care Fund had promoted joint objectives and approaches: the development of coordinated and partnership approaches for public health challenges was less marked. However, national surveys of DPH and CCG members of HWBs showed a slight increase, from 44% (2015) to 58% (2016), in respondents who agreed that HWBs were leading on wider public health challenges, as well as an increase in the percentage of respondents considering that the PHOF was influencing priorities across partners (from 49% to 69%), although numbers involved are small.

Interviewees raised the public health leadership role of HWBs, whether their membership reflected the breadth of public health issues, and their influence on a public health agenda. Some interviewees also made reference to the HWB being unrepresentative and unable to engage with the populations it served. However, there were examples of sites where the HWB was described as integral to working across the system. In one site, the HWB Chair was shared between the local authority and CCG, so that it:

*does both of our business, and so we allow both sides to truly steer and take the programme where it needs to go. So the health and wellbeing board strays unashamedly into health and social care.*

Another site's HWB Chair spoke of debating and clarifying the governance relationship of the HWB and the local authority when the HWB was being established. The HWB Chair pointed out that:

*The Health and Wellbeing Board has statutory functions and if you read the Act it's the Board which makes appointments to the Board, not the local authority. It's only a local authority committee because the government had to put it somewhere and decided to either be part of the NHS or it should come under local government, and they decided to make it local government.*

The Chair went on to speak of the HWB having:

*a really strong set of leaders there, good attendance ... very clear approach to the health and wellbeing agenda.*

This was markedly different from some sites, where decisions on HWB membership were made by the local authority, sometimes without prior consultation. The decision-making role of the HWB was also questioned. An Elected Member commented that:

*The fact that the health and wellbeing board has officers and members voting when it's a sub-committee of the members' council, is also a very difficult position for people to be in and I think that the government needs to either scrap the health and wellbeing boards or change their function.*

HWBs were not always consulted or informed about public health-related decisions. (The leadership role of HWBs is the subject of a separate NIHR PRP-funded research project.<sup>12</sup>)

Closer involvement with the VCSE sector was anticipated by the reforms, but progress varied across sites. VCSE organisations were represented on the HWB in only five of the case study sites, with one site having four representatives on the HWB, reflecting the strength of engagement. In general, VCSE sector representatives had been elected to represent their sector, rather than identified and invited to do so by the local authority. VCSE sector interviewees believed that, as a result, they and the wider community were able to participate in and influence leadership of the public health agenda. Where the VCSE sector was represented on HWBs, interviewees spoke of the difficulty of fulfilling this duty when the sector was so diverse and the infrastructure and associated resources for doing so were minimal. One interviewee summed this up:

*But throughout the third sector, representation's a really weird word because there simply isn't the resource to ever go back and consult with 200 organisations and listen to everything they say and then take that back into a strategic forum.*

Where they were not formal HWB members, there were examples of an 'informal board' with VCSE representatives, an assembly of third sector organisations with a partnership agreement with the CCG, and VCSE representatives liaising directly with public health staff, rather than through the HWB. There were, therefore, marked differences in the nature and extent of engagement across the local authority and the sector across the case study sites. The national survey of Healthwatch and VCSE members of HWBs (n=34, (RR 3)) showed that only 27% of respondents considered that the HWB was a good forum for reflecting views of the VCSE sector, although problems of representativeness, diversity and competitiveness within the sector were also recognised.

One HWB had discussed wider issues such as sustainability, air pollution and housing, and another the extent of food poverty as a consequence of austerity. However, not all sites adopted this approach. Some interviewees described how HWBs regularly monitored performance against short-term indicators which contributed to longer-term public health

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<sup>12</sup> Evaluating the leadership role of Health and Wellbeing Boards as drivers of health improvement and integrated care across England  
<https://www.dur.ac.uk/public.health/projects/current/prphwbs/>

outcomes. Improvements in health were described as influential in increasing ‘trust and confidence’ among Elected Members. An interviewee emphasised that ‘we’re looking across the whole organisation in terms of inequalities’, with inequality analysis regularly reported to the HWB. In this case, this was also considered by the Scrutiny Committee and CCG.

As discussed in sub-section 6.1.3, HWBs were subject to criticism, described as limited by their membership, their place within the governance arrangements of local authorities and their lack of decision-making power. The HWB was one of many arenas for discussion, with decisions often made in separate corporate management or joint commissioning committees. In some sites, children’s partnership boards had been retained which meant that children’s issues, such as childhood obesity or early intervention strategies, were not discussed in detail at the HWB. HWBs were described as ‘confusing’ in a local authority decision-making context and their role in influencing rather than in decision-making or scrutiny was described as ‘difficult to unpick’. One CE described HWBs as ‘constitutionally ridiculous’ and another interviewee argued that further work was needed over the respective roles of HWBs and Scrutiny Committees.

Even within the same site, interviewees held different views of their HWBs, with some identifying improved partnership working with CCGs, partly fuelled by the Better Care Fund and the agenda for integration and others expressing frustration with lack of effective CCG involvement.

#### *Cooperation with CCGs*

In first phase fieldwork, a number of local authority interviewees were critical of NHS engagement but improvements were evident by the second phase. However, the impact of financial difficulties in the NHS were also more evident, putting a strain on relationships with the CCG, described as more ‘inward looking’ (VCSE interviewee) and with more emphasis on the redesign of health and social care than on prevention and health inequalities. A HWB Chair spoke of their CCG being ‘extremely cautious’, and of ‘dragging them [the CCG] along reluctantly’ in the commissioning of an integrated care organisation, but that the service had been commissioned eventually, with immediate improvements. A strategic director in another local authority described progress made in their area, believing that an integrated commissioning board had exhibited:

*the fine art of avoiding putting anything meaningful on the agenda. So the CCGs didn’t want to collaborate with each other, and probably not us either. But through stubbornness and persuasion it has now evolved into a much more meaningful board. And we are joining up a hell of a lot better, and I think our two teams work really well in examples of that.*

National surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) showed that the percentage of respondents who considered that collaboration between local authorities and CCGs was good rose from 81% in 2015 to 89% in 2016. Comments from survey respondents (n=10 (2015) and 8 (2016)) included examples of CCG investment in preventive programmes, and joint commissioning in Vanguard and Integration Pioneer sites. However, comments in 2016 were mixed: further development was needed and there was criticism of a lack of investment in prevention by the NHS. One DPH (2015) commented that ‘they expect local government to fund them [preventive services] instead and don’t see it as their responsibility’. A CCG respondent (2015) noted that ‘it’s all about the frail elderly and preventing admission’. As for links across local primary care services and the local authority, these were seen as improving in 2016 (from 39% to 56%) but again, comments (n=7) were

mixed. There were improvements (such as 'council run and funded Healthy Living Pharmacy and Dentistry programme and 'GP Plus' posts to spend 6 months rotation through council public health and integrated services'), but others commented on effects of cuts on services and 'resistance' by CCGs to decision-making by Elected Members.

Lack of coterminosity across CCGs and local authorities, especially in multi-district authorities could create problems in collaboration, as could the fact that CCGs might relate to different acute providers. Such problems were less evident in single-tier authorities with a single CCG and it was argued that the reforms did not take adequate account of two-tier systems, being most suited to 'neat, coterminous single-tier areas'. Moreover, CCGs were sometimes divided into localities with different approaches.

In some sites, interviewees emphasised the alignment of the CCG strategy (or strategies) with the JHWS and complementarity with wider local authority plans. However, much depended on the financial status of the CCG. Despite a commitment to prevention in the NHS 5YFV, a CCG interviewee commented that 'we are effectively commissioning to our bottom line in the budget book, rather than commissioning to public health outcomes'.

In order to incentivise partnerships, it was considered important to allow rewards to be 'passed round the system', as the financial benefits of investing in prevention were often reaped by other agencies. One CE argued, for example, for greater clarity over how a public health system was to be defined, return on investment maximised and demand reduced.

#### **6.4.4 The public health role of District Councils**

District Councils have responsibility for housing, leisure, environment, planning and licensing. Interviewees raised questions over links between districts and public health teams, coordination of public health services and how far public health priorities agreed at the HWB, for example, were reflected in district priorities. The study showed limited focus at a county level on the public health roles and responsibilities of districts and limited ability on the part of districts to influence county priorities. A District Councillor commented:

*In my personal opinion, I do not believe that the district authorities within {name of site} have really registered their role in health and wellbeing, because it's not something the districts have traditionally done.*

While public health was described as being included in the corporate plan of districts (and, in some sites, districts had their own, informal HWBs and in one case, included a councillor with a public health portfolio), districts were often described as working at an individual level, funding public health services out of their own budgets with initiatives which were often individual and lifestyle-based (e.g. fun runs) or wider community-based projects. In one site, districts were being funded through the public health grant to implement services, with designated public health leads for each district. This meant there was a 'locality feel' to the work. In another site, innovative health and wellbeing hubs had been set up at district level, signposting, providing lifestyle services (including some drug-related services) and also some social prescribing, liaising across housing and leisure (although it was noted that further networking, for example, across children and family centres would be desirable). District Councillors were involved in these hubs as board members. However, despite these initiatives, one interviewee argued that there was little evidence of coordination, either across districts or between districts and the county in relation to public health initiatives, noting:

*There are x district councils with x ways of tackling health and wellbeing. And yes they do have meetings about health and wellbeing, but it's not joined up and it doesn't feed the health and wellbeing board. I, in my simple mind, thought they'd feed in, but they don't. There's no join-up.*

While districts had been provided with public health funds, it was argued that there was little consideration of potential duplication of lifestyle services already funded through the county or provided through the voluntary sector. Some interviewees argued that working across districts and local CCGs could be improved and there were examples of CCGs meeting with district councils to discuss plans. However, fragmentation across districts made collaboration more difficult.

VCSE sector interviewees from areas with multi-district authorities made reference to these challenges, which derived in part from diverse characteristics of the individual district councils and in part from the numbers involved. One noted that:

*District representation (on the HWB) by Elected Members has always been more an attendance than an active role, the two I've known. That may be because ... nobody's briefed them too well, or most District Councillors are interested in their district and if it doesn't affect them...*

Engaging and collaboratively leading public health across county and district areas of responsibility presented challenges for all multi-district case study sites.

It was not surprising that one DPH noted that the reforms worked better in single-tier authorities, where services were brought together under one organisation. Rural counties also led to substantial costs, given the travel time required in order to network across large counties.

In summary, while cross-directorate, partnership and system-wide approaches were considered advantages of transferring public health responsibilities to local authorities, overall there was less emphasis on this aspect than on initiatives to facilitate closer working of public health staff within certain directorates and on the agenda for the integration of health and social care.

Box 9 summarises examples of cross-directorate and wider partnership working highlighted by interviewees.

#### Box 9: Examples of cross-directorate and partnership working

**Tobacco alliance:** (a) In one site, a new tobacco control strategy had been launched (with extensive media coverage) involving an alliance across partners and all departments of the local authority. This included further bans on smoking in public places, including smoke-free outdoor play areas, cited as an example of health benefits to children which involved low cost to the authority; (b) In another site, a tobacco control alliance was chaired by the CE and included the fire service, the police, trading standards and youth services (and linked in to the health inequalities strategy); (c) a campaign against illicit tobacco working with trading standards.

**Alcohol strategy:** includes ban on outside drinking in public places. Examples included councillor support to limit alcohol licensing, despite negative impact on night time economy and employment.

**Food:** local food summits.

**Planning:** (a) regulations on fast-food takeaways within 400 metres of a school; (b) objections to opening of a betting shop; (c) public health input into planning new builds and assessing planning

applications from pubs.

**Contractual changes:** (a) including healthy vending machines as part of leisure contracts.

**Transport:** (a) 20 mph speed limits on side roads across a city; (b) funding transport department to work on cycling proficiency in children (public health budget).

**Housing and public health:** funding 'warm homes'; removal of 'no ball game' signs from Housing trust properties.

**Whole system approach to obesity:** 'sugar smart' and working across local organisations; cycling; planning; contracts for school meals.

**Schools:** working across schools and local authority youth cabinets (and other youth organisations) for young health champions and linked to training opportunities; exercise through schools' 'daily mile'.

#### 6.4.5 Fragmentation across the commissioning system

Interviewees described fragmentation across the commissioning system, although some interviewees considered these mainly resulted from the commissioner/provider split and procurement legislation rather than from the reforms. However, the reforms were considered to have led to fragmentation in primary care commissioning, including immunisation and vaccination; health protection; and data sharing, although again the latter could not be directly attributed to the public health reforms.

##### **Primary care commissioning**

First was fragmentation across primary care commissioning, with three commissioners involved - NHSE, CCGs and the local authority. This was a potential source of confusion for primary care providers. An NHSE interviewee commented that:

*You've got three different commissioners, one poor GP, and they're all thinking 'hold on a minute. Who do I talk to about what?'*

The separation of commissioning responsibilities following the Health and Social Care Act was described as leading to difficulties in keeping everyone informed and involved. An NHSE interviewee described a 'fractured' system, where roles and responsibilities had become unclear, noting that commissioning oversight groups had been set up to address these issues. CCG interviewees also commented on fragmentation of commissioning and the importance of commissioners incentivising providers to work better together.

Implications of changes in contracts (such as for sexual health services) on primary care and clarity over expectations of commissioners required regular discussion. The commissioning split between services for HIV/AIDS and sexual health was also described as posing problems.

Issues were also raised in relation to liaison with practices over immunisation and vaccination: negotiations with independent contractors were described as less effective than the previous arrangements through the PCT. It was suggested that NHSE could do more to monitor and performance manage preventive activity being carried out through primary care. Some CCG interviewees considered that a better balance was needed locally across action on wider determinants of health and prevention in primary care, which had been weakened by the reforms. A CCG interviewee commented:

*I don't believe we're as strong as we were as a PCT in typical health prevention work. So in cardiovascular disease work, diabetes work, etc. ... as a health commissioner before, with public health embedded and part of it, I think we were really good*



*strategic health prevention commissioners, and I don't think we're as strong on that agenda as we were.*

The same interviewee considered that smoking cessation services were less 'joined up' across the local authority and primary care than previously.

A related issue was the input of public health staff into CCGs. The reforms had changed the level of public health input to CCGs and, therefore, public health involvement in healthcare public health and strategies for prevention in primary care. The national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) showed that only one quarter of respondents in 2016 considered that more public health expertise was available to CCGs (from 21% in 2015). In comments on this question, most respondents considered there had been a loss of public health expertise, with one DPH describing it as a 'massive loss in healthcare public health expertise'. This was linked to reductions in capacity due to cuts in the public health grant. However, some sites allocated consultants (and maintained the level of input) for each CCG and interviewees highlighted increased input into CCGs in second phase fieldwork, partly influenced by the development of STPs and a renewed focus on healthcare public health.

#### ***Immunisation and vaccination for school-age children***

Second were arrangements for immunisation and vaccination for school-age children, described as more difficult to arrange since the reforms. GPs were not specifically commissioned to vaccinate school-age children; school nurses were commissioned by the local authority but not necessarily to carry out vaccinations; and there was a lack of clarity over the respective roles of PHE and the NHS. A CCG interviewee noted:

*So you have the public health lead at the local authority not quite sure which way to turn in order to ensure that vaccination rates in our school-age children are maximised. ... you get a fragmentation of service, which becomes quite patchy, and it's different in different areas of the city. It'll depend a little, it's a bit of a lottery because it could depend on whether you have an organised practice that is prepared to do the extra work for frankly no money, and ditto a school nurse service, whether there's sufficient capacity to do it.*

Collaboration and collective commissioning across a patient pathway were described as routes for avoiding fragmentation of the current system, including problems related to immunisation and vaccination.

#### ***Health protection***

Third were arrangements for health protection. Most case study sites reported no difficulties with the new health protection arrangements and some interviewees described improved arrangements, due to closer working with the local authority and, in one case, through working across combined authorities. For example, health protection work could be carried out in environments where public health teams did not previously have access, such as care and residential homes, 'making them safe with respect to flu, winter vomiting bug, aseptic technique ... encouraging them to have contingency plans for various emergencies'. Some interviewees emphasised the importance of informing Elected Members over the health protection role of public health staff and, in one case, the annual DPH report had been devoted to this issue.

In other sites, different views were expressed (mainly by CCGs and NHSE interviewees). While PHE was described as having prime responsibility for health protection, concerns were expressed over whether they could provide the rapid response that was needed, splits in responsibility and whether there were enough 'boots on the ground'. There were reductions in environmental health officers, in the resource available to NHSE and in the public health workforce, all of which affected the ability to carry out key tasks. A DPH noted:

*We can't lose what we did in the NHS in terms of that support to NHS commissioning the healthcare public health, the oversight of some of the health protection services, the oversight of health protection, emergency planning as well. They are all roles appropriate to DPH in the local authority, but it's a huge job and we're having to manage on less resources. ... So it would have been a big job to manage all of this with the capacity we had in the NHS, but it's even more of a challenge now.*

A public health consultant (Phase 1) in another site commented in detail on the 'parlous state' of health protection with 'unclear roles and responsibilities'.

*I feel it's very fragmented, very unclear, very under capacity to deal with significant outbreaks for instance. I feel that there's a huge loss of experienced staff who know how to deal with that.*

It was questioned how serious incidents were being defined in the new system. The national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) provided further information on communication for health protection. While there were slightly more positive responses to this question (from 13% in 2015 to 25% in 2016) most comments (n=9 (2015) and 9 (2016)) were negative in both surveys, referring to 'fragmentation', damage caused by fragmentation of roles and a 'confused leadership system'. One respondent described the current position as a 'dog's breakfast' and a 'risky mess'. However, there were also examples of improvements (2016) including a 'health protection forum with partners', and an integrated 'resilience forum', reporting to the HWB.

### **Data sharing**

A fourth area highlighted by interviewees was data sharing, described as a 'minefield' by one interviewee. Despite the importance of sharing patient/client/person data across sectors, data sharing had become more difficult. It was also pointed out that this was more the result of national guidance on information governance over data sharing, rather than the reforms. A DPH noted:

*The Health and Social Care Information Centre completely fails to understand the importance of local public health departments accessing data.*

Interviewees identified a number of specific problems. For example, PHE was not able to share practice-level data with the CCG or with local authorities; NHSE did not hold patient identifiable data; it was difficult to access data that commissioning support units had access to (such as up-to-date information about flu vaccination and cancer screening in each practice). This meant that DsPH did not have access to the NHS data that they needed, such as immunisation rates at GP practice level. This could also affect the quality of needs assessment and the JSNA.

In some sites, there were local agreements in place, building on good relationships in order to overcome data-sharing problems at a population level and to develop risk profiling, or ways for tracking spend (using pseudonymised data).

Critical views were not limited to CCG and DPH interviewees, but also reflected by some interviewees from the VCSE sector. For example, in one site, VCSE sector staff in preventive assessment teams working with older people could not share the data with the main VCSE sector organisation. The VCSE sector needed to demonstrate compliance with data protection requirements, but often with little support to carry this out.

Comments (n=10 (2015 and 9 (2016)) in response to questions in the national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) identified similar issues. A DPH (Survey 1) noted that 'any access to data is incredibly difficult and sharing rarely occurs', and another that 'the reforms have not enabled information sharing and actually made access to data far more difficult for public health teams'. The vast majority of comments were negative, with one commenting that 'it's transparently clear that data sharing with public health teams by the NHS has been significantly hampered by the reforms'. There was, however, some improvement from a low of 5% (2015) to 22 % (2016) of respondents who considered that data sharing had become simpler since the reforms.

While surveys showed that across most elements of a public health system a higher percentage of respondents in 2016 than in 2015 considered that the situation had improved, this was most marked for collaboration across CCGs and local authorities and use of the PHOF to influence priorities across local partners.

#### **6.4.6 Sustainability and Transformation Plans**

A significant development since first phase fieldwork for commissioning across a system was the introduction of STPs. Regardless of views over their introduction most interviewees acknowledged their likely impact on the integration agenda, primary prevention and early intervention to promote independence. Public health teams were increasingly involved in developing STPs, including modelling their potential impact, but despite their status as the implementation strategy for NHS 5YFV, NHS commitment to prevention was questioned. These issues are discussed in turn.

##### ***The integration agenda***

The STP was described in some sites as encouraging collaboration with CCGs (with an example of a merger of CCGs as a direct result of the STP) and as bringing 'a strategic conversation around integrated commissioning between health and local authorities' (CCG, interviewee, Phase 2). The position was viewed as pivotal by one HWB Chair, who stated:

*If we get it right, the impact will be enormous because we'll have a really good, financially balanced health and social care system. If we get it wrong, the impact will be enormous because we'll have a health and social care system that doesn't work ... So whatever happens this is a really big moment.*

For some interviewees, the STP footprint provided opportunities to integrate commissioning plans over wider areas. Some considered this would support improved targeting of services to areas of greatest need, thereby helping to reduce health inequalities.

### ***A focus on prevention***

A focus on prevention, health inequalities or healthy life expectancy within STPs (highlighted in three sites) presented opportunities for improved commissioning and reorientation towards prevention and early intervention. One DPH was responsible for leading the prevention agenda across the whole STP area. This DPH referred to the STP as ‘the big game in town’, and incorporating prevention within the STP had raised the profile of public health teams. Another DPH considered that the STP had built on priorities in the local public health strategy and had been used to leverage resources from ‘other bits of the system, particularly the health and care system’. A director responsible for adult services spoke of being ‘delighted’ with their STP, even though it had been a ‘difficult journey’, believing that the STP had:

*a very clear narrative around the importance of prevention, the importance of promoting independence, the role of social care and the social care model in terms of improving people’s lives. Rather than what some other areas have got, which is something about the NHS, I guess, if I’m being really blunt.*

One DPH spoke of ‘the modelling, the analysis and identifying what the gap is and what the savings and the benefits would be through prevention activity’. In particular, there was felt to be a renewed emphasis on healthcare public health and secondary prevention. The same DPH (Phase 2) noted that:

*With all the partners round the table, including the secondary care organisations, they’ve been part of those discussions and I think they’ve probably had more to do in public health in that strategic sense than they have done for some time.*

There were also reports of JSNAs and JHWSs informing and being closely aligned with STPs, consequently enabling successful commissioning. However, in other sites the STP was seen as a delivery mechanism for just part of an authority’s JHWS, with the DPH noting that:

*So, in other words, the STP is really around health and care. The wider determinants, which is in the health and wellbeing strategy, around housing, employment, education, the economy, they’re not going to get delivered through the STP. So we have definitely, we are not seeing the STP as replacing the health and wellbeing strategy, but more a delivery mechanism to take forward part of the health and wellbeing strategy.*

Interviewees spoke of the amount of time and resources being dedicated to STPs by HWBs, CCGs and local councils, including project management by DsPH. This reflected a shift since first phase fieldwork, not just in the workload of public health teams but also away from the ‘health improvement leg of the stool’ towards redesign of the health and care system and ‘closer engagement with the risks of health and care system failure on population health.’ (DPH, Phase 2)

While the potential for STPs in reducing demand by working across a system was highlighted, others saw them as not aligned with the role of public health in promoting action to address wider determinants of health. In one site, this distinction had been clarified during the STP process. The DPH stated:

*So that's key for us. So primary prevention is around how people live their lives and the choices that they make, healthy choices. That is absolutely the domain of local authorities and public health to enhance and promote that.*

### **Criticisms of STPs**

Criticisms of STPs included the process through which they were introduced, a lack of funds for implementation and, in some cases, a move away from wider determinants of health and from the views of the public.

#### *A flawed process*

Some interviewees believed that the hierarchical, 'top down' leadership approach of the NHS posed a barrier to successful commissioning. In particular, some criticised the way that NHS leaders had introduced the STP process. A district council representative stated that they had 'watched with horror this STP emerging from nowhere', while a strategic director (Phase 2) believed that there was a 'democratic deficit in the process', stating:

*You need to have a new conversation with the public about what a 21<sup>st</sup> century health and care system looks like. ... Trying to railroad it through, they'll just end up in judicial review and it will say that it's a flawed process, nothing will happen.*

#### *Financial constraints*

Commitment (and capacity) of health commissioners for the prevention agenda was questioned. Scepticism was expressed over the potential of STPs in the context of cuts, and an increased requirement for prevention from local authorities, despite funding constraints. A DPH (Phase 2) noted:

*I think it's a complete nonsense to be talking about an STP and the wish for local authorities to engage in STPs, talking about narrowing the prevention gap, or emphasising, and at the same time cutting the money... . So I wish central government would be consistent in if it's saying prevention is important, then how cutting the public health grant helps in that is quite beyond me.*

Interviewees other than DsPH voiced concern that the NHS was not investing sufficiently in preventive services. A CE reflected that there was a risk of public health services becoming increasingly marginalised and even disappearing, as demands for critical services in both the NHS and local government increased, and resources diminished. While acknowledging that prevention was mentioned in plans, strategies and was 'at the heart of our STP', a DPH also felt that it was 'just rhetoric because they haven't got any money to spend on prevention'. In the same vein, a Director of Adult Services noted that 'there's been significant pressure to write something that pretends on paper that it balances'.

Moreover, it was argued in a number of sites that economic information in STPs was poor, with little evidence for return on investment across the system or on the amount of savings to be released. A DPH (Phase 2) commented that:

*There's no step by step plan, blueprint of how to get there. It just says we will get there by such and such a time, and we will save such and such money.*

A DPH in a different site noted there was a danger of all effort 'slipping into tackling the financial gap'.

### *A change of focus*

Some interviewees viewed STP proposals as moving the focus away from prevention and one DPH (Phase 2) considered that the process failed to recognise 'the needs of the consumer' and the role of primary care in 'recognising the financial and human impact of disadvantage, and being able to work with others to do something about it'.

Moreover, some argued that the main concern of STPs was 'keeping people out of hospital and helping people come out of hospital more quickly' (VCSE, Phase 2). A director responsible for children and young people's services was critical of the emphasis in STPs on adults and hospital care, commenting:

*I'm not trying to prevent kids going into hospital. I'm trying to ensure that parents are quick to be able to deal with their child when they've got common childhood ailments. ... I'm trying to enable them to be confident in parenting ... hospital admissions for children aren't necessarily an issue. It's a different problem, isn't it? We need to understand the problem and I'm not sure in the debates we always do.*

In this case, children's services had been 'insourced' and kept out of 'the STP conversation' in order to preserve the resource.

### *Increased complexity of decision-making*

Some considered that STPs superseded many of the provisions in the Health and Social Care Act. Issues raised included complexity around the role of HWBs and local decision-making arrangements, especially where STPs involved more than two authorities and the risk of 'duplication and confusion'. An added complication was the mix of different regulators and accountability mechanisms, different member organisations with different (and sometimes competing) agendas and different timescales. Differences in governance, auditing and regulating procedures across organisations therefore continued to present some barriers.

Some criticised the geographical boundaries of STPs: one DPH felt that historically and culturally, the disparate parts of their proposed STP area had never identified themselves as being part of the same place, and a district council representative felt that the proposed area was simply too large to be manageable. One interviewee also expressed concern that their area would be 'swamped by the requirements' of the larger local authority/CCG area encompassed within their STP footprint. For some sites, the STP footprint required local councils to work in partnership with even more CCGs, thereby increasing such potential barriers.

Interviewees from a number of sites believed that the associated governance arrangements introduced further complexity into the commissioning system. For example, one strategic director was very positive about the STP proposals and also believed that the HWBs in both of the areas concerned would continue to have a role and purpose. Nonetheless, it was acknowledged that 'there's some work being done' at the moment 'around governance and what governance will look like. So it's too early to say how that will look'. In some cases, it was considered that HWBs did not provide a suitable structure and forum for supporting continued collaborative leadership across a wider commissioning system. Both a HWB Chair and (CCG) Vice Chair believed it likely that HWBs would need to be restructured to reflect these changes.

A further complication was the alignment (or lack of it) with plans for devolution. This was not a barrier for all sites: one site was considered a model for health and social care

devolution, supporting the integration of commissioning plans and sharing of other resources, such as for staff development; another was addressing areas of multiple deprivation in the strategy for the combined authority, led by the DPH. However, others were finding the devolution process a barrier to commissioning. In a number of sites, the proposed grouping of geographical areas was being challenged, and this was hindering the development of structures and plans for closer working.

Moreover, STPs often highlighted different styles of leadership across the NHS and local authorities with each organisation described as making assumptions about the other. Differences of pace and of governance structures added to the complexity. STPs had to be discussed as part of the democratic process in local authorities and some interviewees were, therefore, unclear about their future.

### ***Documentary review of STPs***

A review of the STPs published by the 10 case study sites identified prevention as an aim within all documents, but approaches to achieving this aim differed. Some STPs took a 'provider' approach, outlining how ill-health and unnecessary hospital admissions would be achieved through providing appropriate home and community-based care, information and support of a consistently high quality.

In addition to this, some STPs placed emphasis on enabling or empowering communities and individuals to take action to maintain good health and to improve poor health. Examples of an 'enabling and empowering' approach included giving people a greater say in their own care or supporting people to take action to maintain their own health and wellbeing. However, some STPs proposed moving beyond enabling and empowering to encouraging individuals and communities to accept personal responsibility for avoiding ill-health and unnecessary hospital admissions. One STP acknowledged the wider determinants of health, stating that making healthy lifestyle options was not always easy when people faced stresses, such as poor housing or poverty. While making a commitment to providing professional help, the STP still called on individuals to 'make small changes', advocating shared responsibility. Other STPs were more direct in apportioning individual responsibility. Examples of this included STPs stating an intention to support people to take more responsibility for their care, or stating that the success of the STP was dependent on individuals taking responsibility to stay well and independent for as long as possible.

The footprint lead for one STP was from a local government rather than a NHSE background. Of all the plans, this STP had the strongest and most detailed emphasis on improving prevention through strengthened system leadership and changing the culture of all partner organisations.

### **6.4.7 Enablers and barriers for commissioning for improved outcomes across a public health system**

Interviewees highlighted enablers and barriers for improved outcomes while respondents to the national surveys of DPH and CCG members of HWBs provided comments for an open question on this topic (75 comments in total across Surveys 1 and 2).

#### ***Enablers***

Key enablers included: funding; trust and the quality of relationships; political leadership and authority-wide commitment to public health priorities; a stronger role of national government in prevention; a ring-fenced grant that was protected and audited and subject to 'better national scrutiny' and which also reflected the level of intervention required to

make a change. Leadership from public health teams was important and second phase fieldwork highlighted a shift away from a commissioning role of public health teams towards strategy development and wider involvement across directorates.

Availability of funding was key, along with 'scaling back of the extreme austerity measures affecting local authority services'. While financial pressures were paramount, a few commented that 'lack of funding requires new thinking and partners'. Another identified as an enabler:

*the lack of money, which is forcing people to have unpleasant discussions but be clearer about what local priorities are and how to focus support into those.*

Surveys also illustrated that an important enabler was 'goodwill' and the quality of relationships, whether between individuals, across the local authority and public health teams or across partners and wider stakeholders. One DPH respondent commented on the 'genuine cooperation' needed across the council, the CCG and local NHS providers. This was sometimes described as occurring since the public health reforms, such as in the following comment:

*Much better dialogue in recent times. Recognition of the need for some radical change.*

Closely related to this was an emphasis on local commitment to public health priorities and to change, combined with an effective public health team with leadership qualities (cited by five DPH respondents (2015)). Joint commissioning, devolution and the NHS 5YFV were also described as enablers. Some viewed the leadership of the DPH as a specific enabler: one survey respondent referred to the DPH as providing the 'drive to systematise' and 'facilitatory leadership' was emphasised. However, levels of influence varied and one survey respondent (2016) observed that:

*Directors of Public Health have various levels of influence depending on where the organization has decided to put them ... if they report to another director rather than a Chief Executive this can limit their reach.*

Leadership which focused on clear outcomes and embedded these throughout the whole organisation was also viewed as an enabler for improvement. Strong political leadership was emphasised as an enabler for a 'whole system and borough-wide ownership of health and wellbeing' with one DPH commenting that the 'local cabinet portfolio holder is a great advocate'.

Other issues mentioned included: economic modelling with a better understanding of return on investment, especially on the part of CCGs; and developing consensus over a place-based approach. A DPH respondent noted that 'in less desperate times' the relocation of public health into local authorities could itself be considered an enabler to improving health outcomes.

In second phase fieldwork, increased commitment to inter-departmental working had become a more common enabler for improved public health outcomes. Certain aspects of the STP process were sometimes welcomed for their potential as commissioning enablers. Where there was local agreement on boundaries, the increased footprint offered by devolution proposals was also viewed as a potential enabler.



## **Barriers**

### *Austerity and lack of resources*

Local authority interviewees described pressures of rising demands, statutory requirements (including new legal requirements arising from the 2014 Care Act) and reductions in budgets, although not all sites were equally affected. Authorities were described as a 'shrinking agency' and in 'survival mode'. Cuts across directorates were expected to have repercussions on health and on health inequalities. While the public health budget had been used in some authorities to mitigate effects on children's services and social care, the budget was described as 'insignificant' given the level of cuts across all mainstream services.

There were concerns over plans for local authorities to be increasingly funded through business rates and the extent to which this could jeopardise much of the public health function: effects would be far reaching in authorities where revenue from business rates were low but demand for services was high. Current reductions in both public health staffing and public health services meant that difficult decisions were being made over the balance across core staff and services and how the best value for the budget was to be achieved. Public health was described as less of a priority in the light of immediate demands on local authorities. Others were more forthright in their criticism of how authorities were shielding the realities of austerity and one DPH spoke of a 'conspiracy of sufficiency' to describe the situation where:

*Managers in the system are almost in denial emotionally, personally, politically, organisationally, to say, 'sure we can improve outcomes, reduce inequalities, contain the costs and improve the quality of services, while you take out 23% of the budget'.*

Interviewees expressed different ways of responding to the common challenges of austerity. This was described in one site as involving 'a different relationship between the council and the community' and developing community assets and community development as part of a public service reform programme. There was recognition, too, that the reduction in resources had forced some changes that could be beneficial, in particular, the integration of health and social care which, it was argued, could produce better outcomes for less money.

Interviewee views on the impact of austerity and the unfortunate timing of the reforms were echoed in both national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), where the barrier most commonly raised to improving public health outcomes was a lack of resources – both for the public health budget and for local authorities overall. Comments included: the 'chaos' caused by 'in-year' cuts to public health budgets; the use of the public health budget to prop up social care services and mitigate cuts in local authority funding; a lack of resources to match the rhetoric on prevention in a context of competing priorities; and the ways in which a lack of resources affected relationships with the NHS. The difficulties of implementing further proposed cuts in public health budgets were also raised. One respondent spoke of barriers arising from 'the catastrophic state of public sector finances which has denuded the system of its workforce and is quickly approaching a state of burnout across key senior roles'.

### *'Intractability' of public health problems*

Some barriers in achieving outcomes were attributed to the 'complexity and intractability' of public health problems and 'difficulties of engaging' those most affected by poverty and alienation. Some survey respondents made specific reference to inequalities which were characteristic of their location. For example, one respondent stated that 'rural areas do not

receive sufficient funding to make services accessible to their dispersed communities', while another spoke of 'poor/deprived areas falling further behind (the) national average'.

#### *National and local leadership and support*

National surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) asked whether public health commissioners needed additional support from Commissioning Support Units, NHSE or PHE. Half the respondents reported (2016) that they did not require support from NHSE or PHE while 69% did not require support from Commissioning Support Units. Comments from survey respondents (n= 14 (2015) and 10 (2016)) did not support a greater PHE role at local level, although some acknowledged the value of data and further support for 'health economic tools' to identify savings from lifestyle interventions.

There were also barriers at a local authority level. In their comments for Survey 1 (n=38), survey respondents noted a 'lack of corporate ownership of the agenda', commissioners not 'seeing the big picture' and the challenge of getting some local authority departments to work on public health outcomes or of engaging the wider workforce. Public health was described by one DPH respondent as not a priority for the health and social care economy. Another DPH noted the lack of 'political buy in' to public health, which was not seen as a 'vote winner' (Survey 1). Respondents (Survey 1) also referred to barriers posed by a lack of 'senior officer buy-in', or not 'understanding that everyone needs to make a contribution'. One respondent stated that moving the focus from treatment to prevention 'remains very difficult. Many in positions of authority don't understand the evidence properly'. Other barriers included 'capacity and capability of senior public health leaders', or an adherence to 'old world visions of public health.'

In the second survey (35 comments) some respondents commented that the lack of engagement with prevention was evident among Elected Members, with one respondent noting that public health outcomes were 'seen as too distant' and so not prioritised for funding. This view was reflected when respondents commented on barriers linked to poor leadership, with reports of being 'forced to work to short financial cycles'.

Public health professionals and other interviewees from local government had stated in first phase fieldwork that an important enabler for public health commissioning was a national champion for public health, but that this was lacking. This position was also reflected in second phase fieldwork. The language used by interviewees was more forthright than in the first interviews, with one DPH describing PHE as 'increasingly passive and supine against obvious injustices and not speaking out'. This DPH continued:

*I know they've got their problems, like us all, with having to find cuts and efficiencies, so I don't want to blame any one individual, but I think structurally we haven't really got a strong champion for public health at national level and it's starting to be noticeable.*

Interviewees outlined how this lack of a national champion was a barrier to successful commissioning in two key areas. Firstly, apart from the ring-fenced budget, there were no mechanisms to ensure that local authorities made commissioning or other decisions which benefited public health. Comparing PHE with the regulatory body Ofsted (the Office for Standards in Education, Children's Services and Skills), one DPH noted that should be public health budget ring-fence be removed:

*We're not going to have any carrots, because there isn't any money. What do you do when a local authority isn't delivering what's needed to keep its population healthy and it isn't prioritising it? And I don't think that's really sorted, because the role of Public Health England is very unclear.*

Frustration was also expressed by non-public health professionals, such as an Elected Member who spoke of PHE knowing but being unable to convince the NHS about the need for additional preventive services in their area.

Survey respondents also commented on the need for a strong national voice for public health. One DPH described a lack of national action on alcohol, tobacco, salt and fat and a further respondent (Survey 2) believed the recently published Childhood Obesity Strategy 'missed a lot of opportunities', and called for stronger action from central government. Other DPH respondents noted barriers arising from competing messages from 'big business' and the lack of 'cross-governmental policy development across the Department for Communities and Local Government and DH'.

#### *Capacity of the specialist public health workforce*

While second phase fieldwork indicated increased engagement of public health teams in wider determinants of health, national surveys and fieldwork highlighted difficulties in recruitment, reductions in the workforce and in experienced staff, and uncertainty regarding professional development in public health (see section 6.6.2). In order to enable successful public health commissioning over the longer-term, PHE needed to address how training and continuing professional development was to be provided, ensuring that local government had commissioners with the necessary level of public health knowledge. A DPH commented:

*I don't think anyone has entirely grasped that nettle of terms and conditions, say, moving across local authorities and Public Health England and moving around within the public health system hasn't really been solved and has caused some strange things to happen.*

For some survey respondents, fragmentation of public health teams across directorates, focusing on commissioning services rather than 'being able to act as a specialist public health function' or being 'distant from services they commission', all posed barriers (Survey 2). Difficulties leading and managing the changes presented by cuts in financial resources and the implementation of associated structural and strategic changes, including STPs, demanded significant management resources.

#### *Fragmentation of prevention and organisational complexity*

Survey respondents highlighted barriers to information sharing and organisational complexity within local authorities; between tiers of local government; and between local authorities and CCGs where boundaries were not necessarily coterminous.

Less emphasis on prevention in the NHS since the reforms was also a barrier. The NHS was described by one DPH as 'reinventing prevention without realising that the skills and resources now sit in local government', while another DPH commented that CCGs were not accepting their role in prevention and in addressing health inequalities. Another referred to the 'perverse incentives in the current system and a lack of incentives / outcome measures that promote population health and wellbeing as opposed to measuring treatment processes'.

In summary, therefore, budget restrictions figured prominently in responses related to enablers and barriers to improving health outcomes across a local system. However, respondents also cited lack of corporate ownership of a public health agenda, the domination of the agenda for health and social care and the importance of national action on wider public health issues. Some respondents considered that the public health system had become more fragmented. The complexity of public health problems combined with difficulties in engaging with groups most at risk, were emphasised. Questions are raised over how the public health profession of the future to be developed and sustained and how a national public health perspective is to be achieved for a profession dispersed across many authorities with different priorities and perspectives.

## **6.5 Have the reforms led to innovation?**

### **6.5.1 Introduction**

The extent to which the public health reforms led to innovation has been explored throughout the study and specifically as part of workstream 2: 'Have new public health responsibilities led to innovation in the use of providers, in co-design, in targeting strategies and in models of provision?' Innovation was the subject of a separate research report (RR6).

While innovation is widely seen as necessary and is promoted across both local government and the health sector, it has many different definitions, is associated with different types of change and may be highly context-specific (Audit Commission, 2007). Innovation may be adaptive and evolutionary, or revolutionary (sometimes referred to as disruptive innovation). Although a single definition is elusive innovation, whether evolutionary (adaptive) or revolutionary, signifies improvements in outcomes and processes in a particular context. All represent forward movement and 'adaptation' (evolution) and 'revolution' are often intertwined. Implicit in the concept is the notion and expectation of moving 'beyond competence' (Swann et al., 2005). Leadership and 'buy-in' are often seen as key to overcoming barriers and innovation cannot take place in isolation from those whose behaviour it is intended to influence and change. There is, therefore, a need for a combination of 'top down pressures, horizontal pressures [and] bottom up pressures' (NHS, 2011). It also requires an acceptance of risk. The concept of downward, sideward and upward levers, as applied to innovation in public health in local authorities, may include the following:

*Downward levers:* action encouraged or mandated by national and local targets and strategies. Following public health reforms, there could be friction between these levers, requiring a DPH to balance mandates of central government with those of local government.

*Sideward levers:* innovation via partnerships, alliances or networks across departments or organisations, where partners do not have power to compel other partners to take action, but where all participants perceive benefit.

*Upward levers:* public health challenges and professional responsibilities related to the public health function, such as meeting needs of underserved communities and addressing health inequalities. This may include leverage arising from representation or demand for increased or new services, although demands for health services have tended to predominate.

In practice, levers for innovation are likely to work inter-connectedly. Arguably, where all levers are aligned, the potential for innovation is enhanced. Furthermore, there may be examples of a sole agent applying more than one type of lever. For example, a DPH may act as a sideward lever for innovation through working within a partnership with other local

authority departments or external organisations, but may also act as an upward lever for innovation by making representations to decision-makers in local and central government.

This section begins by summarising how innovation was defined (6.5.2), provides examples of how downward, sideward and horizontal levers promoted innovation (6.5.3) and suggests a framework for considering innovation in public health, reflecting examples from the study (6.5.4). Finally, it reviews how innovation is being encouraged, supported or incentivised by local authorities (6.5.5).

### **6.5.2 Defining innovation**

Interviews with national stakeholders, carried out as part of the scoping study, highlighted dangers of excessive control and monitoring in what was intended to be a locally-led public health system, the importance of engagement between public health teams and Elected Members and of a 'fully engaged' community. However, there was more emphasis on the potential for innovation than on examples of innovative practice. This may reflect the fact that interviews were carried out at an earlier, scoping stage of the study.

Interviewees in case study sites were asked to define innovation in the context of preventive services and public health as were respondents to all four national surveys (both surveys of DPH and CCG members of HWBs; the survey of Local Healthwatch and VCSE sector members of HWBs; and the survey of VCSE organisations involved in health promotion and prevention). Some refused to give a definition of innovation and/or rejected the concept of innovation in public health, considering the term 'over-used' and a potential smokescreen for budget cuts. A CCG interviewee expressed a commonly expressed view:

*I'm not sure that we do anything innovative; we just simply apply what works. And if that's innovative then yeah we're innovative. But actually we're not inventing anything new, we're stealing other people's ideas. There's not much of what we've talked about which is innovative, as in 'new'.*

Others challenged the purpose of the research question. A HWB Chair noted:

*I think it feels to me like trying to find good news really, and it would be misleading for the Department [of Health] to come away and think 'oh actually yeah, we're getting more from less'.*

Evidence of outcome was key and it was argued that 'innovation shouldn't come at the expense of initiatives which have already been shown to work' (VCSE sector survey). Limitations of local innovation in the absence of national action were also emphasised.

Despite these caveats, most interviewees and survey respondents did contribute a definition of innovation, encompassing actions, processes, outcomes, 'a cast of mind', and necessity, given the combination of complex problems and limited resources. Thematic analysis identified nine dimensions of innovation (in various permutations): something new; better outcomes; increased engagement and co-production; risk taking; collaborative action; understanding need; evidence of what works; leadership; and achieving more with less in the context of austerity.

#### ***Nine dimensions of innovation***

*Something new:* newness was, unsurprisingly, commonly associated with innovation, 'trying to do things in a completely new way' (DPH), or 'new ideas and new ways of doing things

and thinking about things by offering a holistic approach' (VCSE sector survey). In particular, both the VCSE sector (n=39) and Healthwatch/VCSE sector (n=34) surveys identified the importance of new and fresh approaches.

*Better outcomes:* For some, being new and untried was less important than achieving a better outcome. A VCSE sector survey respondent noted that:

*Innovation is looking at the fundamentals you are trying to achieve and working out the best way to achieve them. This may not be the same way as you do now. It may be a small improvement on what you do now, or a complete change of approach. It uses new methods, including new technologies, and new providers, not for the sake of newness but because they offer a better way of doing what needs doing.*

In some cases, an improved outcome was the only definition of innovation. For example, a respondent to the survey of DPH and CCG members of HWBs (2015) summed up innovation as 'using a simple approach to make an improvement'. Doing 'what works' was sometimes associated with achieving better outcomes at less cost – that is, both more effective and more efficient. Almost a quarter of respondents for the VCSE sector survey and almost one half of respondents for the Healthwatch/VCSE survey emphasised the importance of providing cost-effective services, achieving greater impact for individuals and the community at less cost.

*Increased engagement and co-production:* engagement with local residents and communities of interest or of place, developing 'shared solutions to common problems', and also promoting local resilience, were frequently mentioned. This was contrasted with top-down approaches to preventive services or adoption of a standardised approach. A CE noted:

*It's a general understanding over time here that ... if you're going to find creative solutions to some of the issues we've got, the answers aren't in the town hall are they? .... We need to work with people in order to get them.*

A further survey respondent noted that:

*There is still a culture of standardised services fitting around people, not a more personalised approach which may be more costly initially but will be the only way to create the behaviour change required in the longer term.*

For others, as well as being 'responsive to people's experiences' and to deficits in services, innovation would also support communities taking responsibility for their own health, encouraging asset-based community development. This was linked not only to effectiveness and sustainability of behaviour change but also to achieving value for money.

A VCSE sector interviewee summed this up as follows:

*If you don't engage the community and getting people to develop and change life styles for themselves and have a sense of local ownership, you can put projects in all over the place. But once you've gone, if you haven't actually invested the time on the local people, once you've gone, you've gone haven't you?*

*Risk taking:* a further dimension to innovation was a willingness to take risks, to try things which were not only untried or lacked an evidence base, but where there was no guarantee of success. A CCG interviewee (Phase 1) noted:

*So when you innovate ... it's going with your hunch. You're saying what we're doing at the moment isn't right. We've got to do something different.*

The importance of experimentation was emphasised, as opposed to what was described as the tendency of professionals to 'draw funding to themselves'. A CE commented that:

*I'm very much into trial and error and experimentation, learning as you're doing at the local level with the people that we have and the people whose problems we are here to solve. Most people solve most of their own problems. When they don't, they get together with other people with problems like themselves and try and solve them socially, so we can help that as well. And when that doesn't happen, they look to the state to help solve these problems through policies or through instruments or through special programmes.*

*Collaborative action:* different kinds of collaboration were raised - with service providers, across directorates, across partner organisations, across counties and boroughs and in relation to specific services. For some, innovation was promoted by changing traditional forms of delivery, working with new providers, including the VCSE sector, and providing 'opportunities/platforms for organisations from all sectors to collaborate to design and deliver local services' (Healthwatch and VCSE sector survey). This could include 'more work and interaction between health and other groups, e.g., transport, housing, fire and rescue, than there was before' (survey of DPH and CCG members of HWBs (2015)). A service director in a case study site believed that 'innovation is coming through the synergy that we find when we bring our collective thoughts together'. In other cases, it was emphasised (by a CCG interviewee, for example) that 'if you have the right relationships, irrespective of organisations, you can still do really innovative things'.

Also highlighted in the first survey of DPH and CCG members of HWBs (2015) was a focus on joined up services across the local authority and the NHS, related to issues such as social isolation, fuel poverty, healthy child programmes and children's centres. A respondent emphasised the importance of public health innovation reflecting an understanding of system complexity and transformation while providing 'additionality'. In the second survey (2016) there was increased emphasis on innovation through redesign related to the integration agenda, and through place-based budgets, which encouraged linkages across services, using shared resources for common 'public health goals'.

*Understanding need:* some suggested that increased engagement, co-production and listening to local residents were necessary for innovation in order to support another dimension, that of understanding need. A service director in a case study site believed that as a result of the public health reforms:

*Innovation has come from assessing needs that aren't being met and looking at ways in which you can begin to address those needs differently.*

As well as responding to unmet need, interviewees and survey respondents also felt an important dimension of innovation was responding on an individual's terms. A respondent to the VCSE sector survey reflected that innovation could be defined as a:

*new response to identified need or to fill existing provision gaps with flexible redesign. Not following trends or perceived wisdom; listening to the end user and then designing the response rather than a 'one-size fits all' approach.*

*Evidence of what works:* the concept of innovation in public health was rejected by some because success did not arise from 'inventing anything new' but on identifying, interpreting and applying the evidence along with a 'good understanding of the data' (CE). However, respondents also emphasised that the innovative aspect of putting evidence into practice was recognising and adapting to the local context.

There were tensions between evidence and innovation, expressed as follows by a CCG interviewee.

*We've got to do something different. So define that in public health. I think what we tend to do, what tends to hamper innovation generally, and I don't know whether this is more or less a public health matter, is our desire in the health system to be evidence-based. But you can't get the evidence without innovating.*

*Charismatic leadership:* the ability to inspire others to do things differently or aspire towards higher goals, was mentioned by only two survey respondents as an important dimension of innovation. However, the importance of negotiation, leadership and networking skills were emphasised throughout fieldwork. A DPH interviewee described this dimension of innovation as:

*having a good story to tell, or having a story and then ...telling it in lots of different places, and particularly as a way of gaining support and commitment from a whole range of individuals and organisations.*

Like many of the dimensions of innovation discussed above, this dimension was aligned with others. A VCSE sector interviewee described innovation as something which:

*comes both from experience and the ability to articulate whatever you're trying to innovate, and it links really in the sense of having the expertise, the knowledge and the research capacity to develop something that you can really put forward as an innovation ... .*

*Achieving more with less:* as mentioned earlier, the drive to achieve more with less led some interviewees and survey respondents to refuse to define innovation because of concerns about discussing innovation during a period when financial resources for public health were being reduced. Of those who did respond, the importance of reducing cost while improving effectiveness was key. A CE interviewee described innovation as:

*coming up with ideas that improve efficacy at lower cost to the public in ways that are different than was done before, and they're implementable.*

While some saw innovation as dependent on increased investment in prevention, one DPH considered 'austerity has become the mother of some quite interesting innovation', forcing collaboration, service redesign and a search for new ways of achieving health gain.



Respondents discussed combinations of dimensions, such as new or creative solutions which provided better outcomes at less cost, or understanding need and evidence with an ability to communicate and inspire others to dedicate resources in order to take action.

As one VCSE sector respondent noted, innovation was ‘the happy marriage of creativity and effectiveness’.

### ***Comparing case study sites***

Analysis by site revealed differences in emphasis, reflected in the extent to which innovation in public health was explicitly promoted from Member level through senior leadership and across all staff; in the role of evidence and implementation ‘at scale’, as opposed to experimentation and local knowledge; in communities as a source of innovation; and in the extent to which the VCSE sector was a partner in developing innovative projects. Interviewees also reflected on innovation arising from the location of public health teams in local authorities, less central control, more local flexibility, closer links with Elected Members and an increase in synergy across public health teams and local authority directors.

Sources of innovation included new providers (leading to new models of provision), user involvement, and adapting good practice to local contexts. Financial stringency was sometimes seen as leading to innovation, but more often as rendering the reforms as a ‘lost opportunity’. For the VCSE sector, innovation could be stymied by a reduction in contracts with smaller and local providers.

In one authority, innovation was emphasised as fundamental and linked to wider transformation of the public sector. Examples of innovation involved investments in small-scale community projects, or the transfer of certain council-owned assets to community ownership ('asset transfer'), anticipated to result in improved health outcomes for targeted communities. This change in ownership also often led to savings in service costs and even the generation of profits. Developing an innovation culture among staff was a key priority and aligned with staff training to recognise the needs of different groups, so that services were not developed in a top-down or bureaucratic way, but reflected the needs of local communities. The HWB Chair for this site noted:

*So it's about developing that culture right through the organisation. Right down to the frontline, so that frontline staff feel safe that they can try something new, do something new.*

In some sites, innovation was specifically linked to the reforms and the effects of synergy across public health teams and local authority services and opportunities for involvement in public health by everyone, from volunteers to senior decision-makers. As one DPH put it:

*The whole point, for me, of being in the council is around innovation.*

Further details by site are available in the full innovation report (RR6).

### **6.5.3 Levers for promoting and diffusing innovation**

In this section, we describe classes in relation to each lever theme which emerged from the analysis of interview data from our 10 case study sites. In all but one site, downward and sideward levers predominated: considering sites as a whole, downward levers were more

commonly identified than sideward levers. In one site only were sideward levers more often identified than downward levers.

### ***Downward levers for innovation***

Interviewees in all sites referred to downward levers for innovation. This could be interpreted as a sign of strong leadership, spreading from Elected Members and senior managers through to departments and communities. It could also be viewed as an indication of revolutionary or disruptive innovation; the result of leaders having to face the challenge of austerity. Five classes are discussed below:

#### ***Strong system leadership, engaging partners outwith the local authority***

Interviewees gave more examples of innovation arising from system leadership than from leadership that was focused within the local authority. The need to lead collaboratively was summed up by a HWB Chair, as follows:

*The big prize, and the only game in town really for me, is that integration of health and social care. Because that is a place where we can make outcomes better for people. We can deliver the service they want from us, and we can save a boat load of cash along the way.*

In another site, the CE described how authority-led support for locality hubs had resulted in the development of a wide range of services including 'health, council, police, neighbourhood ... GPs'. It was emphasised that they were 'about action, not bureaucracy'.

Interviewees varied in their opinion of how an authority's view of the VCSE sector and consequent willingness to lead collaboratively with the third sector affected innovation through provision of grants, or involvement in commissioning.

***Austerity:*** Of particular relevance was the impact of austerity as a lever forcing service change and as an impetus for developing community assets and promoting personal responsibility, moving away from what some viewed as a traditional public health response. A DPH believed that:

*Accidentally in the past we were doing a bit of promoting dependency, rather than promoting independence ... we're giving responsibility back to them. And quite often I think they may be more sustainable, more affordable, and more appropriate every which way.*

However, some interviewees took the opposite view, that austerity resulted in innovative schemes not being funded or sustained and also increased use of the VCSE sector 'because they think that voluntary services are free services that can fill the gaps'.

#### ***Strong leadership within the local authority***

For some interviewees, innovation was a result of strong leadership focused on local authority services and operations. This included strong leadership from Elected Members which facilitated opportunities for cross-directorate innovation. Sometimes, innovation derived from reorganising management structures and responsibilities and sometimes from strategic leadership influencing service level innovation, such as promoting the national 'Making Every Contact Count' initiative. In one site, the CE believed that the public health reforms had given 'ownership and seeing things through, and that's been very powerful ... great ideas and new insights have been brought to bear'. This was reflected in service level

partnership-based innovations such as locality-based hubs and service delivery agreements across directorates to promote public health outcomes. Dispersal of public health teams across local authority directorates was described as a deliberate decision to support public health 'infiltrating and influencing different departments'.

While strong internal leadership, especially by Elected Members, was viewed as a lever for innovation by some, there were examples of such leadership being viewed as a barrier to innovation, with some Elected Members being unwilling to take risks or 'go with a hunch'. For example, a NHSE interviewee believed that Elected Members' concern with meeting financial targets over-rode their interest in innovation:

*You sometimes get that real barrier from the politicians which is 'well our budget's been cut so we can't do it'. So it's in some respects a kind of conversation stopper.*

#### ***Contract-based innovation***

Innovation through the contract derived from competitive tendering and requiring targeted outputs. Specification, outcome measurement and value for money elements of local authority procurement processes were highlighted. However, some VCSE sector interviewees, in particular, found the competitive commissioning processes inflexible, limiting or even prohibiting VCSE sector involvement. The VCSE sector interviewee for one site reflected that as a result:

*Some of the innovation and some of the opportunity to put in our ideas has been lost. We are basically the same as [a] private provider, tendering to meet their outcomes.*

However, the view was also expressed that requirement to compete promoted innovation:

*When you're getting grants year on year, there's not the necessity to be innovative. When you've got a position whereby you've got to try to apply, it makes you evaluate and look at how you deliver that service to try to fit their needs.*

#### ***Innovation resulting from securing additional resources***

Two interviewees spoke of opportunities for innovation arising from successfully securing additional resources. A service director in one site described the local authority as 'brilliant at getting pots of money for innovation', and went on to describe projects which had public health benefits but also supported other objectives, such as developing small businesses or supporting digital inclusion. The time when the public health budget was being transferred had, in one case, provided 'a little window of innovation opportunity'.

#### ***Sideward levers for innovation***

Partnerships, alliances or networks were a common trigger for innovation although as discussed above, this was usually combined with sponsorship from political leaders (downward levers). This reflected the view of many interviewees that public health reforms had increased opportunities for partnership working.

#### ***Partnerships with a 'general population' focus***

Most examples of innovation were for services for the general population, such as through partnership with CCGs, leading to 'really creative' work on social prescribing' (HWB Chair). There were also examples of new partnerships with local government services, such as partnership for smoke-free public places between public health, community protection,

licensing and events management. The DPH in one site described responsibility for the leisure services commissioning budget, which had provided an opportunity to 'rebrand ... the whole of the leisure offer', aimed at the whole population.

New partnerships had also been established with other statutory sector organisations, including the fire and rescue service (3 sites), with home safety visits described as 'much more holistic ... they can liaise with other people within the authority ... also giving out the public health messages' (HWB Chair). Locality-based information hubs were being delivered through partnerships with a range of other agencies. Examples of innovation arising through partnerships with the VCSE sector included: supporting independence in older people through time-limited intensive support; utilising volunteers as health messengers and role models (including a training programme on health messages, signposting and referral); and VCSE sector organisations based in (and delivering services from) local authority community buildings, such as libraries. There was an example of partnerships for adult health across national voluntary organisations and the CCG. In one site, an innovation partnership across the VCSE, local authority and CCG had been set up to 'build community capacity and self reliance'.

#### *Partnerships focused on specific groups*

Many partnerships focus on the needs of specific groups and are of long-standing: those highlighted through the research as being innovative included: new arrangements for services for children and young people; victims of crime or those at risk of offending; mental health services; and support and services for older people.

In one site, a partnership approach had led to early years' support, including FNPs, health visiting and Sure Start all being provided 'under one roof'. The HWB Chair believed that this had resulted in 'all the pieces of the puzzle for early years' support' being brought together, leading to 'critical' benefits. There were also examples of partnership approaches to tackling childhood obesity such as 'sugar debates' in schools, working in partnership with national campaigns and whole system approaches across retailers, employer and statutory organisations. Enthusiasm from head teachers for encouraging exercise before the school day for all ages was cited as innovative, low cost and highly effective. In some cases, parents were also participating.

Innovative partnerships established to address the health needs of people who are victims of crime and/or people at risk of offending included an innovative partnership with the CCG and police, which involved mental health social workers being based in police stations to assess and support people with mental health needs. This had resulted in a significant drop in the number of people with mental health needs being held in police cells inappropriately. Another site had worked in partnership with a prison to address drug and alcohol abuse and suicide prevention. Two sites highlighted their partnership approach when planning domestic abuse services.

As already described, many partnership-based innovations supported good mental health as well as other outcomes. One site also gave an example of work led by public health to support people with very limited incomes to manage their finances and avoid debt, through working in partnership with welfare benefits advisors and credit unions.

Innovative partnership approaches to meeting the needs of older people were also mentioned. Some examples were of partnerships providing direct finance for innovative solutions, such as one site with an Adult Health Care fund for pump priming 'spend to save'

initiatives. Other examples were of partnerships with the VCSE sector to deliver services. In a further site, voluntary organisations were organising tea dances, and delivering advice and practical help, as part of a 'keeping warm in winter' project.

#### *Partnerships concerned with ICT and data-sharing services*

There were examples of innovation arising from ICT-focused partnerships. Sites reported data-sharing arrangements, such as one site which reported a 'Big Data' project, a multi-agency project sharing live performance data which practitioners could access from their desktops. Another site described establishing a joint health intelligence unit with a neighbouring local authority and associated CCGs. There were also reports of innovative collaborations to make use of ICT to support public health outcomes. One site had 'innovation hubs', which brought together staff, service users and technology support to develop innovative solutions. A further site had invested in an interactive online drama, while online counselling services were also being developed for a number of sites for children and young people. A service director reported that the:

*cost is miniscule, touches the lives of thousands and thousands of young people. They find it really accessible, they communicate on the internet, that's how they engage. And it's a really creative, accessible service that is really well used by individuals.*

Others gave examples of recognising changing preferences and using existing ICT to deliver traditional services, such as one site which used Facetime<sup>13</sup> to deliver health visitor services in rural areas.

#### *Supporting partners to commission services*

Collaboration for commissioning specific services included a partnership with neighbouring local authorities and health services to deliver sexual health services. Although it was too early to have strong evidence of success, the service director felt that it was a 'good example' of innovative partnership working, because sexual health was a very complex area and it was difficult to judge at a local level whether a drop in clinic attendance was an indication of success or simply the result of people obtaining services elsewhere.

A positive outcome of the public health reforms had been opportunities to benefit from local government commissioning expertise and infrastructure. In one site, the DPH noted their appreciation of the move to local government which had allowed an alliance to be formed with a 'very good procurement lawyer' who was able to do 'very innovative things with contracts'. They went on to compare this with their previous experience where this was 'not the NHS's forte'. In a further site, the DPH believed that public health staff were giving practical help for the design and evaluation of innovative approaches proposed by other partners.

#### ***Upward levers for innovation***

Classes which reflected upward levers for innovation were derived from interviewee descriptions of services developed in response to unmet needs in specific groups or in specific areas; voiced needs identified through co-commissioning (for a range of different groups); issues where there were complex and interrelated problems which demanded innovative solutions; and community-based engagement activities sometimes developed into far-reaching strategies for maximising community assets, including developing and utilising community interest companies and social enterprise. There were examples of

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<sup>13</sup> Video telephony

innovation arising through working with communities of place through developing locality-based commissioning strategies and annual HWB 'listening events' at local community level.

The most frequently mentioned examples of innovation were those arising from leverage exerted by children and young people. Some of these services had been developed as a direct result of public health teams and their partners adopting principles of co-design or from understanding and responding to the characteristics and preferences of young people, such as the online mental health service in one site, which proved a popular means of service delivery for young people, many of whom might not have sought to engage with a traditional face-to-face service. Other services were innovative for the site in question, but were based on evidence of success in other geographic areas, such as a basketball court or a street dance project, where the leverage arose from young people choosing not to engage with other services aimed at encouraging exercise.

There were also examples of co-design to support those at risk of crime or at risk of offending. These included domestic abuse services and also a review of substance misuse services in one site, which involved service user representatives and informed the tender for the prime provider contract, resulting in improved outcomes.

Innovation arising from leverage by BMER communities included research with community organisations and 500 residents as part of a review of hepatitis B/C among BMER communities. This had raised awareness of the needs and preferences of this community among health professionals as well as among community members, and had led to improved outcomes for public health services relating to liver disease.

Finally, there were examples of innovation arising from the need to meet the needs of underserved groups, where new ways of working were required.

When reflecting on advantages arising from the public health reforms, many interviewees expressed a view that addressing health inequalities was not possible without greater community engagement. They spoke of the reforms leading to public health services being more in touch with local communities, and of increased opportunities for co-production and co-design. This was also reflected in the surveys of Healthwatch and VCSE organisations. However, when considering levers for innovation, communities of place and communities of interest, identity and/or faith had less influence than downward or sideward levers. Although case study analysis is qualitative, not quantitative research, it is notable that in some sites, interviewees made no reference to innovation arising from leverage exerted by community groups. Meeting the needs of underserved groups and addressing health inequalities, therefore, tended to emerge from local authorities and their public health teams fulfilling their public health responsibilities. This was encouraged through close working at ward level between public health teams and Elected Members, evident in some of our sites.

While separated for analytic purposes, levers work in tandem. For example, in one site, strong leadership provided a 'downward' lever which fed through to 'sideward' and 'upward' levers of innovation. A local authority-level decision to reduce funding to the VCSE sector and to adopt a community assets approach was translated at a service level to new intra- and extra-authority partnerships. At a community level, it had supported upward levers resulting in place and need-based innovative projects. However, achieving innovation through strong area-based leadership appeared more difficult when the local authority was part of a much larger conurbation and where communities of interest may be dispersed

across a number of local authority areas: innovation could, however, derive from pan-conurbation approaches (for childhood obesity and sexual health services).

The extent to which innovation in public health commissioning occurs partly depends on how these levers are aligned, how initiatives and approaches are applied to a framework for public health commissioning and how this is translated into a local context.

The following sub-section illustrates projects related to 11 elements of public health commissioning.

#### **6.5.4 Developing an innovation framework for public health commissioning**

The research proposal identified the importance of developing an 'innovation framework for public health commissioning', in order to support future relevance of the research. This section illustrates an innovation framework with examples from the study. It is, therefore, contextual and is not intended as a comprehensive assessment of sources of innovation in public health. As a snapshot in time, some of the projects identified may have been discontinued since interviews and surveys were carried out, or new ones may have emerged.

##### ***Innovation illustrated***

Examples of projects and initiatives are provided for eleven key themes related to public health commissioning. These are illustrative, with a more detailed account in RR6.

- (i) *New services commissioned through public health teams:* New responsibilities had the potential for extending a public health perspective across traditional local authority functions and services and were sometimes reflected in training of other local authority staff. In one site, for example, planning was in place for public health representatives to deliver training to newly qualified social workers, to give them an understanding of public health and key roles within it. New responsibilities for public health teams included leisure services, preventive elements of the Care Act, place-based services and management of social fund and community care grants.
  
- (ii) *Public health skills in health needs assessments and data analysis contributing to targeting and mapping across directorates:* Many interviewees highlighted the contribution of public health skills in marshalling evidence, data analysis and health needs assessment. There were examples of public health teams providing research skills in directorates where research activities had been curtailed due to cuts. Some interviewees also highlighted the contribution of public health teams in identifying the impact of cuts on services. Some public health teams had focused on detailed ward-based analyses, working with Elected Members and promoting local understanding and commitment to public health issues. These skills were now being applied to services over and above public health services, including children's services, for example, where they were described as increasing the effectiveness of targeting. This was innovative in the sense that it could inject a new public health perspective into services traditionally provided through the local authority. As one interviewee noted:

*How can we put added value into what the council is already doing, with a public health hat on? And that is largely around what's the evidence base? What are the outcomes? How can we actually get more for our money? How*

*can we help improve the lives of people through our contribution? So I think that is the innovation and it's happening everywhere across the council to a greater or lesser extent.*

There was more evidence across sites of such activity in services for vulnerable groups than for wider local authority services, although there were also some examples of public health analyses and perspectives being applied to planning and to the impact of concentrations of fast food outlets.

- (iii) *Providing services through expanding and developing a public health workforce:* While sites often reported a decline in the number of public health staff, they also reported methods for exploiting the public health potential of the wider local authority workforce. These included education and training opportunities at different levels (including Masters in Public Health) for local authority staff, pharmacy staff and dentists and adoption of 'Making Every Contact Count' for public health purposes, so that health-related advice and referral across local authority services could be provided by a range of staff (e.g. housing). This could be included in contracts with housing associations, for example. There was also an example of ethnographic training for all adult social care staff. One DPH spoke of leisure service staff 'who are highly qualified and know a great deal about health improvement', but who needed to expand their skill set. This DPH stated:

*Too many people think public health is a ... small clinical specialty that was part of the NHS – we have to stop looking at public health in that way. Public health is the system. It's the whole system. It's the way we should be, you know, it's the bedrock of society systems and organisations.*

One example was the use of fire and rescue services for health improvement, where home safety checks had been developed to identify wider health and care support needs and consequent referral. There was, however, some difference of opinion amongst interviewees over this initiative if it fell outside the management of the public health team. More generally, engagement of a wider workforce could itself be considered as innovative.

- (iv) *Developing within-directorate and cross-directorate approaches to improving health:* Promoting health considerations within and across directorates was not always innovative but rather a continuation of public health-related initiatives which pre-dated the reforms. The reforms were, however, perceived as legitimising and galvanising these approaches. As discussed in sub-section 6.4.3, there were numerous initiatives designed to embed public health approaches within and across each directorate, including public health service delivery agreements.
- (v) *System-wide approaches for specific public health challenges:* Interviewees described a wide range of local authority involvement with other partners, with the aim of improving health-related outcomes, from support for homeless people to addressing childhood obesity, although many such initiatives were well-established and not related to the reforms. However,



with a few notable exceptions, sites had not developed sustained multi-agency approaches to complex areas such as childhood obesity, as one example of a public health problem that requires action across a whole system. Integration was seen as promoting innovation through breaking down organisational boundaries in order to achieve the best value from the budget across the system.

- (vi) *Re-commissioning preventive services:* Interviewees and survey respondents identified a wide range of preventive projects (summarised in section 6.2.7 and in RRs 3-5). In most case study sites, preventive services inherited from the NHS had been reviewed and re-commissioned to reflect greater integration and a holistic model, closer links with other local authority services (including children's wellbeing, housing, looked-after children and domestic violence), more emphasis on social aspects, and co-production and peer support in services, such as those for drugs and alcohol. There were changes in providers and in contracts, with the latter including more detailed specifications and monitoring arrangements and an emphasis on cost-effectiveness.

For drug and alcohol services, there were examples of services being integrated, co-produced, linked with other local authority strategies, focused on family impact, and re-commissioned in ways that were moving away from 'professionally dependent' to more community-based models. An example of this was a recovery model for a drug and alcohol service where those in recovery volunteered to support the next group coming through, so 'you're strengthening the approach of that whole community, and taking that forward'. Interviewees also described being able to re-commission sexual health services which were more integrated, and co-produced. They were sometimes tied into the VCSE sector (with an example of VCSE sector support being funded through the CCG), increased use of online services (where a drop in demand had been demonstrated) and more community-based services.

In one site, a less clinical approach to weight management had been adopted and replaced with a multifaceted systems-based approach. This included: a more upstream and whole family-based approach which was better targeted; a separate service for men; a combined approach (including behaviour change, physical activity and healthy eating); and funding for a wider systems approach. This involved action from other council departments and partner organisations, including local businesses and schools.

This illustrates how innovation derives less from one innovative intervention than from combinations of approaches, combined with a shift in emphasis.

- (vii) *Commissioning through co-design and community engagement:* As described in section 6.2.8, co-design of services as part of the commissioning process was already well-established in local authorities. Public health teams are able to benefit from these links and, as mentioned earlier, there had been close involvement of public health teams in using co-design as part of the re-commissioning process for services for sexual health, drugs and alcohol,

domestic violence and for CAMHS. Use of technology was a key feature of co-design involving young people and there were examples of co-design of web-based services created and designed by young people and of an innovative interactive online drama, developed through co-design and subsequently made available nationally.

- (viii) *Changing the provider landscape:* Changes in the provider landscape were highlighted as a potential impact of the reforms (see section 6.2.3). Innovation in case study sites was identified through changing contracts with existing providers, changing providers, involving the VCSE sector for specific services, involving the local authority workforce, pharmacies and dentists in health promotion and the encouragement of community-based projects.
- (ix) *Working with community networks and localities and developing community assets:* It was argued that pressures on the health and social care system from long-term conditions meant that communities had to become more involved, taking more responsibility for improving health and wellbeing. Often referred to as 'asset transfer', was the drive to stimulate community enterprises and provide public finance to community groups on the basis of their providing greater social value. This was often linked to public sector transformation.

Some sites were supporting large numbers of community champions, while others focused on 'whole authority' community volunteers. One example, funded through the CCG and the local authority, was of an early years' programme in a deprived ward using community champions to target the 40% of parents locally who did not use children's centres or other public provision. There were also physical activity champions. Survey respondents highlighted the use of 'health buddies' identifying those at high risk of TB and of coaches, using person-centred approaches and concentrating on building skills to help people 'manage their own behaviours and make sustainable changes'.

- (x) *Targeting services and addressing health inequalities:* As discussed in section 6.2.6, case study interviewees reflected a broad range of approaches to health inequalities, including an emphasis on vulnerable groups. Public health investment was often directed to 'early help' initiatives. Highlighted projects included: 'listening events' with BMER communities; identifying service needs for those affected by HIV; needs of migrant communities; and of travellers. Since the reforms, local Healthwatch in some sites had also become involved in identifying the needs of these groups, although not always working closely with public health teams. In one site, Healthwatch had worked with national and local VCSE sector organisations, as well carrying out local engagement activities to address access to health services of a wide range of groups including BMER and LGBT communities, homeless people and those experiencing rural and social isolation.
- (xi) *Commissioning for wellbeing:* Closely linked to commissioning preventive services was a wide range of community-based projects which aligned with local government aims to increase community wellbeing. These ranged from general initiatives to promote healthy walks and use of green spaces,

through family or community-based approaches, to specialised projects designed to promote skills and enjoyment whilst reducing social isolation. Councils could also encourage initiatives promoted by other organisations, such as 'Good Gym', where runners could build in social value through working on community projects or supporting older people en route by 'running with a purpose'. Innovation for healthy lifestyles was linked to social innovation.

The surveys of Local Healthwatch and VCSE sector members of HWBs highlighted targeting, developing community networks, integrated approaches to wellbeing and prevention, a single referral route for health and social care workers for preventive services provided through the VCSE sector, and the use of smartphones and skype.

The survey of VCSE organisations involved in health promotion and prevention asked for examples of innovative projects: 62 projects were highlighted by respondents (see RR3), and the importance of recognising and addressing social isolation and mental health problems was particularly emphasised. Projects included: initiatives to address social isolation in fathers who had limited contact with their children, or who lacked a support network: gardening for unemployed people, homeless people, and the most socially excluded: and projects for those suffering from mental health problems or dementia. In one such project, designed to offer a range of activities for homeless people as well as address problems of access to services, a VCSE sector respondent noted the benefits of their project on mental wellbeing and employment prospects. An integrated and holistic approach was common to many projects, combining mental health and social wellbeing, while some (e.g., alcohol services) formed part of wider programmes. Advocacy was often combined with peer support and volunteering. Access to cancer screening services, for example, could be developed through training local people to act as volunteers, encouraging earlier take-up of services. Activities (such as gardening, cooking or physical activity), as well as being therapeutic in their own right, could provide a way in to a wider range of services and support for vulnerable groups, including those with mental health problems. One project for homeless people offered 'cookery, arts and crafts, gardening, walks and educational day trips', addressing issues such as access to a wide range of services, poor housing, lifestyle choices and self-confidence. These examples illustrate social and holistic approaches to prevention in the context of council responsibilities for promoting social wellbeing.

#### **6.5.5 How innovation is being encouraged, supported or incentivised**

Some authorities prided themselves on their innovative approach. A HWB Chair (Phase 2) noted:

*I think generally what we've done is promote a culture of giving staff time and space to be innovative. I mean I told them, everybody talks about evidence based practice, but if you're using evidence-based practice you're copying what somebody's done. Innovation by its very nature is something new, so there isn't any evidence. So you evidence it as you go along.*

Local authorities were described as promoting a climate for innovation through awaydays, engagement events (such as speed-dating to develop new service models and partnerships) and there was also an example of an innovation award. Innovation through cross-council working with partners (including academic partners) was cited as being promoted through stakeholder events led by the HWB, multi-agency community wellbeing partnerships and via STPs. Commissioning was described as a route for encouraging provider innovation through the nature of the contract - a formal mechanism for promoting innovation. There was an

example of the budget being used to encourage innovation through supporting a number of PhDs in priority topics, such as childhood obesity and adverse childhood experience.

The study also sought to identify through the two national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)) if there were specific routes through which local authorities encouraged or incentivised innovation and whether there had been changes over time. National surveys asked respondents whether the local authority had created a climate for developing innovative approaches to public health across a range of different areas, such as prioritising areas where innovation was needed, providing time for rewarding innovation, facilitating cross-directorate working, using the public health budget to encourage innovation, and developing integrated public health services. A comparison of the surveys (see RR6) shows a greater percentage of positive responses across all dimensions in 2016 than in 2015. Areas where there was most agreement over local authority support for innovation were in facilitating cross-council working with key partners (86%) and commissioning integrated services (also 86%), while the greatest improvement in support since 2015 was in the areas of testing new approaches, learning from failures, providing financial incentives for improving health through innovation and commissioning for integration.

In the national survey of Local Healthwatch and VCSE members of HWBs (n=34), while over 40% of respondents considered that the reforms had led to innovation in targeting services to underserved groups and areas, addressing unhealthy lifestyles and taking account of social context and conditions, there was less awareness of impact on co-design, use of incentives or improved access.

#### **6.5.6 Summary**

This section has demonstrated that innovation is subject to varied and discipline-specific definitions. In this study, we adopt a contextual approach, reflecting what interviewees and survey respondents considered innovative in their respective local contexts or organisations and have not sought to impose a single definition of innovation as a yardstick against which examples are to be judged. The report therefore reflects ambiguities associated with the term.

The distinct contribution of the public health reforms to innovation can be difficult to assess, given financial and other pressures to transform the public sector, which are ongoing, and the existence of innovative approaches which predated the reforms. Moreover, the parameters of what is included under the rubric of 'innovation in public health commissioning' are shifting in the context of broader conceptions of commissioning for wellbeing in the public sector.

Co-location of public health teams, combined with a programme for re-commissioning services funded through the ring-fenced public health grant in the light of local authority procurement procedures and priorities, have encouraged a combination of increased community involvement and co-production, connections across preventive and other local authority services, less emphasis on single interventions for unhealthy behaviours, greater recognition of the family and social context and the need to adapt good practice to local circumstances. Surveys of DPH and CCG members of HWBs indicate that for community involvement, co-commissioning and identification of underserved groups, changes were in the direction anticipated by the public health reforms.

In addition to changes in traditional preventive services, there was also potential for innovation through public health perspectives being applied to traditional areas of concern for the local authority, new responsibilities for public health teams in areas such as leisure, and involvement across directorates, such as environment or planning, although public health involvement was less evident than in 'people' directorates.

It is clear from the nature of many public health challenges that a combination of the elements described in the public health commissioning framework is often required, to include community engagement, actions across the wider system and the choice of providers reflecting a more holistic and contextual approach.

Whether innovation is encouraged or implemented in practice partly depends on the existence of 'levers' promoting innovation and the extent to which these levers are aligned or are in opposition. While the framework provides an opportunity to reflect on patterns of public health innovation and change by authority, the analysis of downward, sideward and upward levers for innovation can help identify enabling factors and the sustainability of individual projects for each element of the framework.

## **6.6 Leadership and accountability for public health**

This section explores complexities that arise in developing the leadership role of local government in promoting health and addressing health inequalities. Eight themes are explored: transition of public health teams to local government (6.6.1); influences on the leadership role of public health profession(6.6.2); hallmarks of successful public health leadership across local authorities (6.6.3); working within democratic decision-making structures and through Elected Members (6.6.4); the influence of the evidence base in priority-setting (6.6.5); the role of scrutiny (6.6.6); trust and relationships (6.6.7); and the broader leadership responsibilities of local government (6.6.8). The leadership role of HWBs across a local system is discussed in sub-section 6.4.3.

### **6.6.1 Transition of public health teams to local government**

#### ***New organisational arrangements***

In the former PCTs, DsPH were executive directors, accountable to the CE with 'an equal vote' and able to speak 'in an equal way at the public board meetings'. They were involved in strategic development across health improvement, health protection and health service improvement. The transfer to local authorities resulted in a change of emphasis and a wide variety of organisational and accountability arrangements for DsPH and for public health teams with implications for a leadership role, deployment of the ring-fenced public health budget and the level of cross-directorate working. Through comparing findings from first and second phase interviews we were able to illustrate how these arrangements changed over time.

Analysis of first phase interviews reflected three main models, although there were numerous permutations: a separate public health directorate; dispersal of public health staff across directorates; and a senior public health team but with operational accountability to the directorates in which public health staff were based. In one site with a separate public health directorate, the DPH held responsibility for a wide range of services (e.g. housing-related support, libraries and community engagement)<sup>14</sup>. In two further sites, a separate

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<sup>14</sup> In this context, it should be noted that a combination of disparate responsibilities is common in local authorities given the trend for combining responsibilities under fewer directorates.

public health directorate was largely focused on public health-related services and in another, the focus was on public health intelligence, while commissioning public health services was the responsibility of an Executive Director. There was also an example of a public health directorate acting as lead agency for domestic abuse specialist services (funded through the public health grant). Leisure services also formed part of DPH commissioning responsibilities in some sites (not always as part of a separate public health directorate). One CE expressed the view that a separate directorate reflected the importance of public health and was essential if its credibility was to be maintained:

*So that was something I did very deliberately in the end because I felt that it was important that the function was given that kind of level of reach in the organisation. And my sense is, in looking at some organisations, that where they bury the directors of public health in the guts of the organisation then the focus is lost a little bit.*

The second model involved dispersal of the public health team across local authority directorates. This often included incorporating some (and sometimes most) public health staff into centralised corporate information/intelligence and commissioning services (and, in one case, strategic services). This was the direction of travel in a number of sites, even where DsPH currently held commissioning responsibilities. In one site, however, the public health team had a separate performance and commissioning group, which developed strategy related to the public health grant.

There were examples of mixed models, where operational accountability was through the directorates in which individual public health staff members were based but with a small senior team accountable to the CE. Staff were typically based in children's services, adult social care or community services. Reasons cited for dispersal included promoting relationships, improving cross-directorate working, enabling theme-based work across the authority and achieving 'more interfaces with more people'. One CE commented:

*We did not want to see public health tagged on as a department, a specialist department somewhere in the chief executive's unit. We wanted public health to be completely integrated into the council, influencing every part of the council with a key line of sight to me and Elected members. So it has affected that, it's created opportunity and challenges.*

Some argued that where public health was constituted as a separate directorate it could be viewed as an 'outpost' and could lead to public health responsibilities being seen as resting with the DPH, rather than with the authority as a whole. A CE reiterated that it was 'the understanding of the whole council that makes public health really work. If you keep it in a box separated out from your organisation ... you will marginalise it and you will have less impact'.

Across sites, there were numerous examples of public health teams carrying out needs assessments, data analysis, targeted strategies for particular groups across directorates and providing services in different locations (such as youth centres and libraries).

Second phase fieldwork showed some important shifts. Where public health services were already dispersed and/or integrated into other directorates, such as those for adults/adults and children or corporate commissioning and insight services, the situation was unchanged,

although there was variation in the extent to which public health was still seen as a separate activity. In one site, for example, a DPH (Phase 2) noted that:

*Public health service managers ... manage between them the whole of the adult early intervention and prevention agenda, not just the public health bits of it. So, in other words, we're not organised in the way that a public health department with very narrow portfolios was organised in the NHS. This is the way in which you actually embed a public health way of doing things across a council, make it council core business.*

In another site, the Director for Adult Social Services was the lead on healthy lifestyles as part of a directorate incorporating public health services, as well as services for adults and children, and where the DPH was one of a number of directors reporting to the corporate director of adults and children. Integration often meant that individual commissioning responsibilities rested with the relevant service managers.

Where public health was a separate directorate (which was the case in five sites in first phase fieldwork), changes had taken place, often connected with internal reorganisations. In two sites, public health had been incorporated or merged with other directorates, meaning that professional advice was no longer located in a separate directorate and in a third, there were additional responsibilities and a new separation of commissioning responsibilities for adults and children. In one site, the public health directorate was small with staff largely dispersed. In the fifth site, however, the change was in a different direction with the DPH holding new Chief Officer responsibilities for place-based services. This was described as demonstrating that 'public health has therefore become more central to the thinking of the council' and as a 'deliberate move' to 'put the discipline, as well as the ethos of public health, around prevention and earlier intervention'. This provides a marked contrast to the more usual alignment with directorates for children and adults and was described as a commitment to an upstream approach and 'the universal offer to communities, and how that improves health, wellbeing, prosperity, skills'.

Although dispersal, assignment or integration of public health staff across departments – and sometimes in each department - was common across sites, the relocation of staff from a separate directorate into a directorate, such as for adult social care, was not always welcomed. One DPH noted the value of public health as a 'neutral brand, pursuing good health for the public wherever we go' and the potential dangers of being identified with one part of the system at the expense of others, including the NHS, while another commented that:

*Amongst the public health community if you talk to people, the first question they ask you is 'who does your DPH report to?'*

It was pointed out that pressure on social care budgets could reduce resources for public health services. In relation to this, one CE (Phase 2) was explicit about the role of public health teams in promoting 'organisational resilience' and risk management and 'more of a reach if you like in terms of health and social care design'.

### **Accountability and reporting arrangements**

A separate public health directorate implied formal accountability of the DPH to the CE. The second model was accountability of the DPH (as a non-executive director) to a Service or Executive Director, although titles and roles of directors varied by site, reflecting different organisational arrangements which obtain in local authorities (e.g. Directors of Adult Social

Care, Children's Services, Communities, People). By the second phase, DsPH reported directly to the CE in three sites and in a further site, there was dual accountability. However, formal accountability of this kind did not preclude authority-wide responsibility for specific areas, such as civil contingencies, membership of corporate management teams or of various executive and senior partnership committees. DsPH were often members of senior management teams. Given there were often very few directorates, each with a large number of responsibilities, such accountability arrangements were viewed as inevitable by many local authority interviewees, although sometimes described as not welcomed by DsPH. Professional accountability of public health teams was to the DPH although a dispersed model could mean that arrangements needed to be in place to ensure this continued.

Of more significance was accountability to Elected Members (DsPH could report to more than one Elected Member depending on their responsibilities) and, in particular, the portfolio holder with responsibility for public health. As described further below, this meant DsPH had less autonomy over decision-making than they had experienced in the former PCTs. A DPH described the focus on:

*briefing the councillors with the responsibility for public health because the decision-making process is different and at official council meetings it is the councillors who speak and not the officers. That is the way that local democracy works.*

There was, however, less central direction than in the NHS, which meant that 'the ability as DPH to work with the councillors to shape how the function works is greater'.

DsPH and their teams worked alongside cabinet leads, HWBs and Scrutiny Committees, although the extent to which the latter took an active interest in scrutinising public health outcomes was variable. For cabinet leads, portfolio allocation could be influential as Members who chaired HWBs could encompass various responsibilities, singly or in combination (for example, children's services, adult services, social care, community wellbeing and public health). In some sites, they also held the position of Leader/Deputy Leader of the local authority, which added to the influence of the HWB. While the view was expressed that a mix of portfolios enabled connections to be made across local authority functions, others considered that a cabinet member focused on public health served to strengthen and provide a focus for this agenda. An Executive Director noted that:

*We've designated a public health champion on the cabinet. We haven't just given it to the adult social care cabinet member. So we have a designated public health champion. The health and wellbeing of the city is now one of our main priorities, which it wasn't before.*

#### *Public health support for CCGs*

One of the mandatory elements of the transfer, and reflected in the reporting categories of the ring-fenced public health budget, was support for CCGs from public health teams in areas such as prevention, detection of early cancers, screening and immunisation programmes, interpretation of data, health needs assessments, priority-setting and programmes for long-term conditions. There was often a memorandum of understanding in place, although the importance, or relevance, of this was sometimes questioned, especially where there was a culture of effective partnership working.



In the majority of sites, DsPH were formal (usually non-voting) members of CCG governing bodies although, in practice, input could be limited, especially in large geographical areas with more than one CCG. Public health consultants could be allocated to each CCG, while still retaining responsibility for public health-related themes across a wider area; CCGs could work with a range of public health consultants; or, as in one of the sites, members of the public health team could simply provide advice when asked. However, in most sites, interviewees saw this support as having decreased since the transfer of public health teams to the local authority and some CCG interviewees expressed concern over a reduced focus on prevention in primary care. Reductions in public health staffing levels also meant there was less time to engage with CCG priorities. In contrast, in one site, the importance of a continuing and substantial public health role in CCGs was particularly emphasised and reflected in the public health budget allocation. There promoted influence over the whole of the CCG budget (rather than over the relatively small public health budget).

Second phase interviews showed little change, although STP development had encouraged greater collaboration with CCGs overall. There was one example of a public health consultant employed part-time by an NHS trust in order to gain direct public health support which helped spread public health input across a local system.

#### **6.6.2 Impact of the reforms on leadership of the public health profession**

Following the reforms, public health staff had been dispersed across PHE, NHSE and local authorities. Interviewees commented on actual and potential effects of the reforms on the public health profession, expressing uncertainty over its trajectory, future role and sustainability, as well as highlighting positive aspects of developing a broader public health workforce. Interviewees raised initial transition difficulties, reductions in public health capacity, differing levels of embeddedness across the local authority and uncertainty over the future shape of a public health workforce.

##### ***Experience of transition***

Experiences of the transition from the leadership model of the NHS to that of local government varied. Some had worked closely with local government prior to the reforms and found the transition smooth, even 'seamless'. In two sites, there had been extensive integration of health and social care prior to the reforms and a tradition of cooperation.

However, the process of transition was also described as a 'culture shock' for public health professionals (and sometimes for local authority service directors, too). The prestige attached to the profession had been dented, according to some interviewees, partly because of changes in accountability arrangements (as described above) and partly as a result of the lack of acknowledgement of a consultant role within a local authority context. One DPH argued that 'local authorities are still not keen to have consultants with consultant grade' and some consultants had recently been employed under a local authority contract, rather than a consultant contract. A CCG interviewee noted that 'most of the public health staff I've come across ... were not very happy in the transfers and the way it was done, and the changing roles and responsibilities that they felt they had'. Elected Members, local government officers, DsPH and CCG interviewees spoke of difficulties arising from cultural issues, such as differences in use of language, to more fundamental challenges such as Elected Members being not fully aware of the spectrum of public health activities or of all the implications of their new responsibilities and DsPH having difficulty adapting to an organisation where they were less autonomous.

In a few sites, public health was seen by some interviewees as being in a 'bit of a bubble', while in others it was largely integrated. There were comments in a number of sites over cultural differences. In one site, public health staff were described as follows:

*I think public health practitioners tend to be reflective people who produce a lot of reports. Politicians are often people that want to see things changing immediately, short-term stuff. So I think culturally there are those difficulties.*

In another site, similar views were expressed by a local authority assistant director:

*I think the mindset, if you like, of public health professionals is a health service mindset which is very different from the local authority. It's much less outcome focused, it's much less self-critical, and it's much less driven by notions of financial accountability within finite timescales. ...they are two completely separate worlds.*

Further challenges arose from having to learn to work within local government committee structures, with one DPH commenting that this slowed down the decision-making process. However, Elected Members in some sites also showed frustration with DsPH not fully understanding these different decision-making structures when they took up their posts. Reference was made to a DPH having 'some difficulty, in my opinion, getting to grips with the democratic process'. Another interviewee (HWB Chair, Phase 2) spoke of the challenges in changing the culture of the inherited public-health workforce. The new demands led one DPH (Phase 2) to comment that it was:

*challenging but it's actually quite exciting in terms of the challenge to the way we think. And I think we're almost at a point of needing to write a new public health handbook for local government practice of public health, because the handbooks haven't really caught up with the reality of practising in local government.*

The requirement for DsPH to produce an independent annual report in the public domain, for example, was considered by one interviewee to reflect 'a privileged position' in relation to 'financial, legal and managerial' controls on advice in local authorities. Some DPH reports were clearly aligned to local authority priorities and interests, covering issues such as planning, the role of schools in promoting health, and the health of children and young people, to include looked after children. Interviewees in some sites commented on the reports being very well received by Elected Members. In other cases, however, the value of the annual report was questioned, as reflected in this view from a HWB Chair:

*I'm not sure what difference it makes that a public health director within a local authority needs to be making a statement on an annual basis. I don't know what good it does or how much notice is taken of it.*

The view of local government interviewees was that leadership of public health was best placed within local government, that public health had 'come home', and that the reforms would be beneficial for both the public health profession and the public. However, challenges continued and were summed up by a DPH as follows:

*I think it's making sure we've got that leadership, making sure that public health is valued and around the table is still one of those areas that we're working on. It's interesting. It's fascinating. And, I suppose ... it's going to remain challenging for some time.*

However, there was also some variation in sites in how much control was exercised by Elected Members as opposed to officers and one site was described as an 'officer led council'.

National surveys of DPH and CCG member of HWBs (n=39 (2015) and 36 (2016)), (and where DsPH were a majority of respondents) showed similar results in response to the statements 'DsPH are able to exercise an independent voice', with just over 60% of respondents in agreement for each year, although CCG respondents were less in agreement. One DPH respondent commented, however, that 'this nonsensical myth of independence creates more problems than it resolves'; a second that DsPH were officers and therefore 'cannot really exercise such a voice'; and a CCG respondent noted that it was 'hard to beat the corporate culture of our LA, don't feel they [DsPH] get to say what they need to say'.

While some NHS interviewees continued to voice concerns about transition, by the second phase most local government interviewees, including DsPH, generally felt that these issues had either been resolved or that progress towards resolution was being made. Overall, second phase DPH interviewees showed increasing confidence in their local authority role, with one interviewee commenting that 'it's quite nice to be out with the council rather than in the bubble of the NHS' and a further DPH noting:

*As director of public health I now have some concerns that the NHS is a bit strange and I feel very comfortable in local authority world! As a DPH who was a local NHS DPH for a very long period before transferring and I think that's probably, I can't speak altogether for the rest of the team, but I think that we are, in terms of that psychological transition we're definitely further on.*

There was still some variation and one public health interviewee (Phase 2) described a state of 'prevention under siege', with little understanding of the role of public health teams on the part of senior executives or Elected Members.

### **Loss of capacity**

Loss of staff in local authorities was highlighted in most sites, with posts not being replaced and less specialist support available for commissioning or health protection. The capacity of public health teams had been reduced, sometimes dramatically, with over half of the staff lost in some sites. There was also ongoing loss of staff through retirement. A consultant noted that:

*Roles which were senior strategic leadership roles have been changed in local government to be middle-grade manager roles and colleagues have had to either like it or leave.*

Public health was described in one site as a 'closed shop with dwindling members' and there had been disruption in two sites due to a succession of interim DPH appointments and difficulties in recruitment. There was also an example of numbers of staff remaining stable, though with a different skill mix and team structure, due to influx from members of staff from other local authority departments.

With a few exceptions, there was less involvement or interaction with primary care and with the NHS in general. This meant that capacity to work with CCGs on healthcare public health

or to influence their strategic decision-making had diminished in most sites. One DPH (Phase 2) summed up the situation:

*I've been in public health a long time and I can see that our remit is broader and our expectations to deliver against that remit is much bigger than it ever was, but we have less than half the capacity that we did.*

While this was described as the result of cuts and consultant posts not being replaced, there was also an opposing view that very few specialists were needed. A HWB Chair (Phase 2) noted that:

*Of course you'll still need the professional professionals, if you like, but I just think you don't need an awful lot of them. Because actually what they should be doing is overseeing the whole process, so actually the public health work can be done by a wide range of people.*

Key issues, therefore, concerned the 'minimum critical mass of staff' required to influence change through policy, play a strategic role across the local authority and fulfil statutory responsibilities. A connected question was the balance to be achieved between funding (and replacing) public health staff and commissioning preventive services. In a comment in the national survey of DPH and CCG members of CCGs, one DPH respondent highlighted problems of recruitment and its impact on leadership:

*There is an absence of public health leadership with no substantive DPH or Consultant in PH in post for more than a year. This is having a negative impact on PH being able to strategically influence and preventing innovation.*

### **Future roles**

Influencing and networking skills were emphasised by interviewees and there was also increased emphasis in second phase fieldwork on a strategic as opposed to a commissioning role. One DPH cited the challenge to 'find health gain in settings you are not familiar with, I suppose' while another commented on the importance of 'a certain kind of personality, a certain kind of recurring pattern of behaviour and thought that make you a good public health specialist'. There was increased emphasis on advocacy, public engagement and mobilisation for public health.

One DPH believed that the future of the senior public health profession in its current form was dependent on 'whether a council respects professional expertise or not ... There is an issue about how much that is actually respected or wanted'. Some interviewees questioned the extent to which relevant skills were the province of a particular profession or whether they could simply be dispersed across the organisation. One interviewee reflected the extent of ambiguity over the role by asking 'in itself, is public health a function? Question mark'. Others questioned whether public health skills were fully understood across the local authority and by Elected Members. The latter sometimes raised the high cost of consultants, due to terms and conditions inherited from the NHS. This remained a concern in second phase fieldwork. The future of the profession in its current form was questioned by a senior manager:

*I think the other disadvantage is that over time it's quite likely that public health practitioners will become local authority officers and you'll lose the clinical governance and the clinical input, potentially. I think that will happen.*

Although Elected Members and strategic directors spoke of respecting public health expertise and skills, this was often qualified. When considering future arrangements, a CE stated:

*I think that the role of public health will be fully assimilated within local government. And I don't think, do you know what, I don't think I'd be appointing a DPH, I'd be looking at a different role, much more around public resilience, and then, yes looking at a whole system.*

This CE suggested commissioning expertise from a third party, when required. There were already examples of shared arrangements in case study sites and, in one case, a shared DPH could commission specialist services and advice from a wider pool. Specialists were increasingly being involved in managerial roles with increased responsibilities and there were signs of a shift away from commissioning services. A DPH (Phase 2) noted:

*I imagine not as many people calling themselves public health colleagues, because there's less money for them. Probably not such a huge amount of money going out and commissioning services that respond to the issues we're trying to tackle, but something much more sustainable, and something much more a core part of senior leaders' roles, both in the local authority but in other partner agencies across the city.*

#### **Recruitment, training and professional development**

In terms of professional development, some public health interviewees cited less sharing of good practice, a decline in regional or sub-regional involvement and more professional isolation. One interviewee, for example, saw little future for the profession, considered that senior strategic roles had been degraded to middle-grade management roles, reported that many public health staff had left or taken early retirement and that it would no longer be seen as an attractive career option for junior doctors. One consultant expressed this as follows:

*I cannot believe it is sustainable and for me that's why I've already started to exit from public health, because I don't see a future for myself in it.*

Another commented on the 'existential threat to the public health function in local authorities'. There was a loss of talent from the profession and interviewees commented that recruitment of experienced people was affected by difficulties in transferring NHS terms and conditions to a new post. A DPH commented:

*There are these issues coming into the system about, 'I don't want to lose my continuity of service; I don't want to lose my big redundancy payment; I don't want to go onto local authority conditions when I'm at a stage in my career where I've built up quite a lot through other NHS terms and conditions' - that is actually a real problem nationally, I think.*

These concerns were reiterated in second phase fieldwork. There was uncertainty over opportunities for specialists to continue the level of continuing professional development required for them to retain public health registration, as this was not readily available in local government settings. One DPH believed that in future, fewer people would enter public health through specialist training routes such as medicine, as 'increasingly more

people are coming through the non-training route, through the portfolio route'. How future DsPH would develop the specialist knowledge that the role required if their career remained solely with local government was unclear.

Second phase interviewees considered that, partly as a result of the development of STPs, there was increasing emphasis on healthcare public health. Availability of training through placements was questioned, however, which meant that not only public health capacity but also capability in this area was under threat. It was also questioned whether local authorities fully appreciated the importance of investing in healthcare public health. This situation was summed up as a 'mismatch in terms of the public health workforce and its future need'. One DPH expressed frustration with the current system as follows:

*I've specialised within commissioning healthcare, so my role essentially was taken out of the NHS as a strategic planner, understanding population need and value and evidence base and reducing health inequalities, moved into local government and then deployed from local government back into the NHS, but without being employed by the NHS, so it's a really strange set-up and we're managing to be as effective as possible within, frankly, quite a crazy system.*

#### **Developing a wider public health workforce**

Reservations about the future of the public health profession were sometimes counterbalanced by optimism over developing a wider public health workforce, the benefits of 'growing a more generic health and social care workforce' and ensuring that 'public health work was done by a wide range of people' (HWB Chair, Phase 2). One DPH emphasised that:

*We've just got to stop thinking about the public health workforce as people who've got public health in their title ... actually we need a workforce that is working in a public health way with those behaviours which are not just about 'have you got the 10 competences that the Faculties say you need to have?' You need to have a different attitude as well... . Actually, what I want are people who have that asset-based collaborative approach to working with communities.*

This was reflected in suggestions for developing graduate apprentice schemes in local authorities and, in one site, there was a clear progression strategy for public health, from graduate entry to service manager, with opportunities for professional development at each stage. A more integrated approach to a public health workforce was also evident in discussions of school nurses and health visitors.

Developing a wider workforce was linked to encouraging all staff to focus on public health outcomes (who could also be encouraged to lead by example) and by developing new and inclusive approaches to skills development and training that were suited to the local authority workforce. 'Skills escalators' could be created, enabling all staff to 'connect people into health improvement services'. The increased popularity of adopting a portfolio route for training increased the diversity of public health specialists and practitioners and opportunities for 'developing skills and knowledge and experience through their everyday work' (DPH, Phase 2).

One DPH believed that there was 'a wealth of talent of people within local government who would make excellent directors of public health'. The challenge, therefore, lay in attracting existing local government officers to train as public health specialists so that they could be

deployed back into local government. In a further site, it was suggested that over the longer-term, public health specialists would be replaced by a larger pool of staff with broader skills.

### **6.6.3 Hallmarks of successful public health leadership in local authorities**

When asked to define hallmarks of successful public health leadership in local authorities there was considerable agreement among interviewees from all sectors, although some commented specifically on the importance of leadership of DsPH and their teams, some on generic leadership characteristics, such as motivational skills, and others on the leadership role of the local authority as a whole.

#### ***Authority-wide leadership and commitment***

The most important hallmark of public health leadership of local authorities was the extent to which the impact of different influences on public health outcomes was understood and then embedded across the local authority directorates and across the portfolios of all Elected Members. This meant the local authority saw itself as a 'public health organisation, and recognised that, for example, 'actually public health, a bit like safeguarding, is everybody's business'. Interviewees commented on the importance of a focus on citizens and their wellbeing, of changing public attitudes towards health and illness, and of all local authority employees 'owning' the public health agenda. Some sites were reflecting their new role through borough-wide publicity, festivals, showcase events and activities and extensive use of social media.

A sign of effective public health leadership would be that 'the public health question comes up, or the health question comes up in every discussion'. Where, for example, a life course model was reflected in the organisation of services, with wider determinants of health incorporated in each phase, the potential for integrating public health actions across the local authority was heightened.

National surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), reflected positive assessments of the extent to which public health concerns were being embedded within local authority directorates (78% (2015) and 75% (2016)).

#### ***Collaborative leadership for public health***

Many interviewees spoke of the importance of collaborative leadership in relation to public health. This referred to an ability to lead across local authority internal boundaries, to lead across partner boundaries such as with CCGs and the VCSE sector, and across community boundaries. Collaborative leadership skills included being able to 'spot the overlaps', being able to build relationships, being able to influence, and finally being able to engage with the public. The outcome of collaborative leadership would be shared responsibility for achieving health and wellbeing, including sharing responsibility with communities and individuals. A key issue was the extent to which public health teams had successfully moved from 'quite a narrow NHS world into a big local authority partnership world'.

Interviewees across first and second phase fieldwork emphasised this ability to communicate and inspire, as an important hallmark of public health leadership. Interviewees spoke of being able to 'bring good messages', of being 'a passionate advocate for health inequalities ... who has got a vision for the preventive agenda and can lead that work'. Much, therefore, depended on the level of influence and negotiating skills of the DPH and the extent to which the DPH was recognised as a leader within the local authority and on 'an equal par with all the other directors'. A NHSE interviewee commented:

*So I think it comes down the strength of the director of public health, the visibility of the team and how the local authority have maintained that corporate director level post for the director of public health.*

Possibly because of the recent changes, interviewees spoke of the need to 'maintain the identity of public health', the importance of 'championing public health both internally and to the wider community' and of achieving political credibility. Systems leadership, the ability to 'bend' mainstream funding and exert influence were all key.

One DPH (Phase 2) focused on leadership and advocacy for public health, but believed it could be sustainable and even more powerful if leaders learned how to exploit the new opportunities presented by social media and thereby 'bring about positive social change and reduce inequalities and get people politically engaged in some of the actions that we need to take to improve health and wellbeing outcomes at the population level'.

As previously discussed in section 6.4, leadership across a public health system also requires public health teams to work beyond the local authority and, as described by an NHSE interviewee, to act as a 'key player in influencing and negotiating and working across the system'. In this context, a DPH questioned an emphasis on commissioning preventive services, preferring to focus on the importance of influence and leadership across a system:

*Is commissioning of services where public health should put its focus? Or should it be about having a skilled public health workforce that can influence others and lever in money that way?*

However, one CE (Phase 2) emphasised that the complexity of system governance, increasing demands for services and decreasing resources, was leading to a possible over-reliance on a 'heroic leadership model, which is not replicable and it's destructive', noting that:

*Because the systems and structures are so hard and there's so few of us now to maintain them. So you're actually, you're having to dig into your personal capacity and capabilities more.*

### **Political leadership**

Elected Members were particularly conscious of their responsibility to their constituents and needing to account to them in order to engage their support. One HWB Chair described successful public health leadership as 'taking people with you ... to take decisions which can impact on their long-term life prospects'. Another HWB Chair spoke of 'failing our population' if this did not happen. Councillors in some sites were described as committed to the public health agenda, acting as 'advocates and ambassadors' and addressing deprivation in their wards, sometimes through their grants. Public health teams had carried out ward-based presentations with councillors to get their views, which had informed the evidence base for the JSNA. In one site, for example, each local community committee had a councillor acting as a health and wellbeing champion. Some councillors had undertaken training (RSPH level 2).

Part of a leadership role for public health teams was described working at a neighbourhood level (such as supporting neighbourhood development officers to work with councillors to develop ward plans) that is, combining both local and strategic roles. An Elected Member with responsibility for public health described visiting local GPs with the DPH to find out



their perspectives on local problems. A HWB chair (Phase 2) commented on the benefits of closer working across public health teams and Elected Members:

*I think they've found that it's very much enriched their work to have a very street level understanding from members.*

Some second phase interviewees described increasing involvement of Elected Members in the public health agenda, including leading by example, attending and endorsing events, incorporating public health messages in regular newsletters to constituents, delivering leaflets and committing to training and development in public health matters, including mental health, in order to improve their leadership. Some were involved in ward-based development of commissioning, including healthy lifestyles remodelling and leading on issues such as prevention of crime and alcohol misuse to include impact on health and health inequalities. There was also an example of a 'leader's summit' on a public health issue. Avoiding health becoming a party political issue was important and one DPH noted that the public health portfolio holder sent out reports to Members across all political groups:

*So we get quite a lot of support from the other political groups, because they get a cabinet report every month and everyone's quite positive about health ... And I think also stops it being a bit of a political football,*

Second phase fieldwork reflected increasing commitment of Elected Members, with one DPH commenting:

*They thought it was all about drains in the beginning, but they've actually come on a journey with us.*

The least mentioned hallmarks of successful public health leadership were leadership arising from technical knowledge, or 'having a good understanding of the evidence' and command and control leadership, described by one CE as being able to 'force people to be cooperative'. While technical, specialist expertise offered by public health colleagues was valued in local government, and access to such support was important, it was not always fundamental to a leadership role. For the reforms to be successful, every leader had to be a public health leader.

#### **6.6.4 Working within democratic decision-making structures**

Although Elected Members hold ultimate decision-making power, there were examples of sites where the DPH had delegated authority for making most decisions, and of sites where there was positive engagement between Elected Members and DsPH, with one DPH speaking of how there was a 'focus on briefing the councillors' and how they now 'work with the councillors to shape how the (public health) function works'.

The position of the DPH within the local government hierarchy was also not necessarily a barrier to positive, collaborative leadership. One DPH who did not report to the CE described a working environment where people had ample opportunity to meet and speak informally with the CE and Elected Members, concluding 'If I want to go and talk to the Leader, I can go and talk to the Leader'. In another, while an Executive Director held the commissioning budget, the DPH emphasised that 'because she's so collaborative and always discusses with me what should be done with it, I welcome that because I don't have to do all

the budget management, but I know I've got the influence and the sign-off, so we work very well together'.

As described earlier, in a number of sites, public health staff were dispersed across local authority directorates, but this was also not necessarily a barrier to leadership, either of the public health agenda or of public health staff continuing their professional development. One DPH spoke of being:

*a little freed up to work more cross-council so more under wider determinants. Having said that, obviously, we are continuing to provide that professional direction for anybody that has got public health skills, and so they still need a lot of direction in terms of their work. So although it's not line-management, there's a lot of professional direction that continues.*

However, there were examples of sites where location of the DPH within a hierarchical structure was considered of key importance. A number of interviewees stated that the decision to place the DPH as directly reporting to the CE had been made deliberately to ensure and protect the leadership status and authority of the role. One CE spoke of wanting:

*public health to be completely integrated into the council, influencing every part of the council with a key line of sight to me and Elected Members.*

This suggests a different leadership culture from those sites where the DPH did not report to the CE but nonetheless was integrated, could influence and had direct contact with the CE, directors and Elected Members. A DPH in another site referred to having been 'knocked down a peg in the hierarchy and this is a very hierarchical organisation', and being expected to:

*go back and check every time, often on a weekly roundup you tell the Elected Member what you're doing. Is that all right, boss?*

In this site, the DPH reported being expected to advise and negotiate with the lead Member before being authorised to speak to any other Elected Member, and of significant decisions being made about public health resources without their involvement.

The change in leadership status of DsPH was acknowledged across the spectrum of interviewees: leadership within local government, regardless of the level of collaboration, retained an element of command and control because ultimate power was held by Elected Members. Maintaining relationships with Elected Members was, therefore, key. One DPH noted that 'if you make yourself too unpopular then you completely cease to be heard. And then you've lost any opportunity'. Others described making particular efforts to communicate with and engage Members on their terms, with one reflecting that 'part of my leadership role is to help them with their leadership role'. While a NHSE interviewee had observed that not all Members had a 'good grounding in public health issues', many DsPH found they genuinely wished to fulfil their leadership role successfully, and believed that progress had been made. A number spoke of welcoming their new way of working and this collaborative leadership role providing opportunities to challenge national government policies, to have 'more local autonomy', and to benefit from Elected Members 'voting local authority money over' to support and protect public health services, which might otherwise be cut.

The importance of influencing and networking was widely recognised, as reflected by one DPH who stressed the importance of taking the issue ‘out of the public health box and put it into the box that sings to where the political leadership are going to go’. However, political priorities varied greatly across sites. In second phase fieldwork, too, there were comments on the impact on the public health budget of politically expedient decisions.

There were other challenges associated with leadership based on political mandate. Difficulties associated with the election cycle were acknowledged by most interviewees, particularly the tendency to concentrate on short-term rather than long-term outcomes and the extent to which this was incompatible with public health planning. Some district councillors were described as more concerned with their individual wards rather than with the needs of the wider population. Other interviewees were critical of the cabinet system within local government, believing that it placed too much power with a small number of Elected Members and reduced opportunities for other Members to influence decision-making.

Nevertheless, most interviewees felt that that politically driven decision-making of this kind was not widespread in their experience, with one commenting that ‘we are very fortunate, we’ve got a sensible council’. Moreover, challenges were not necessarily greater than those posed by centrally controlled leadership, which generated criticism for mandating services which did not always reflect local need, or for promoting investment in interventions (such as on childhood obesity) where the evidence of efficacy was limited. Elected Members and local government officers, including most DsPH, appreciated the legitimacy which a political mandate gave to public health leadership but there were challenges in incorporating evidence-based leadership as part of the DPH role.

Generally, second phase fieldwork had led to DsPH and Elected Members building relationships and building trust. Some DsPH still found themselves in structures and cultures which hindered networking and so posed a barrier to embedding public health across the local authority, but this was a minority. DsPH were also generally positive in their comments about how Members had accepted their new role, understood the mandated elements of the budget, and provided positive role models. A DPH (Phase 2) noted:

*We’ve been quite good at getting them to see the wider impacts of good public health intervention on other things that they maybe care more about actually than they do about the public health interventions per se.*

#### **6.6.5 Evidence and decision-making in a political context**

Many interviewees welcomed the expertise in data analysis and evidence brought by public health teams. One CE commented:

*And I think what is really good about public health is that they have evidence-based approaches - and {the DPH} throws it down our throats all the time but she’s right to do it - is that money shouldn’t be spent unless it’s very clear that the outcomes will be delivered. And so I like that approach.*

However, even in sites where there was a strong culture of collaborative leadership, there was discussion over the balance of ‘evidence-based leadership’ and leadership arising from a political mandate. Although DsPH may have developed collaborative leadership skills, building alliances with Elected Members, officers and other stakeholders, and communicating effectively, this did not necessarily lead to Members using evidence as the

primary basis for decision-making. One director described public health adhering to a leadership culture based on a:

*clinical mind-set which says 'this is the evidence, that's what you should do'.... . But it doesn't recognise that other people see the world in a different way, and may not think that's important, even though the evidence says you should do it.*

A DPH commented in the same vein:

*I think one of the problems that we've got with local authorities and Elected Members, in particular, is that they do not have a very high regard for evidence. Whether that's evidence of need, which they think they understand because they think they've been elected from a community and they know that community, or evidence of what is effective, because that's just not something that crosses their radar most of the time.*

A number of DsPH expressed frustration over a lack of response by Elected Members to the evidence base on particular issues and concerns were expressed by several CCG interviewees over difficulties of getting health professionals to 'trust Members and a political system'. Interviewees outwith local government were particularly concerned that decision-making could be politically driven rather than evidence-based. A VCSE sector interviewee commented that:

*They couldn't, for example, I don't know, advertise sexual health services for young people without the express acknowledgement and support of the Elected Members whose wards that was going to happen in. And I think that was a massive shock for public health staff, who were used to thinking 'well as long as I'm meeting my objectives that's the point', to actually finding that there was this kind of political element inside it as well.*

A DPH (Phase 2) saw this as one of the disadvantages of the reforms, describing a 'weakening of the evidence base and rationality in some of the decisions that we make for public health' through 'putting public health directly into politically-controlled organisations'. The volume of debate was described as more focused towards 'political, local political interest and slightly away from the evidence base'. This could lead to tensions between a political position premised on limiting interference of the state in people's lives and the importance for public health outcomes of encouraging people to adopt healthier lifestyles. It could be argued, for example, that adults, unlike children, were accountable for their lifestyle choices. One DPH noted:

*We had a workshop for Elected Members about the budget in the future and somebody said 'well everyone knows they shouldn't smoke so I don't see any reason at all why we should spend any money on stop smoking services'.*

Another DPH commented:

*What do you do if an authority starts doing something which really is going to have a negative impact, because you get a political drive in that says we're not interested in this stuff, if people smoke or drink that's their problem, you know, we're not interested in health inequalities. If you get an authority that does that and makes that decision through local politics, is anyone going to come in and actually protect*

*that population? I think that is the big question. So I think that question being answered is something that Public Health England really needs to think about.*

These decisions could affect not just the balance of service provision but also the roles and responsibilities of public health teams. A DPH (Phase 2) commented 'anything that is about trying to tell the population the way it should live or behave generally is not something we would be looking to lead'.

There was also recognition that decision-making was not simply a technocratic matter, but a function of values expressed through democracy. A DPH argued that:

*You've not just got a scientific and technical rationality about where it's most important to invest the money to improve health and wellbeing, but in the decision-making about where you invest, that is still important, but you're also valuing public preference expressed through the political representation in that place.*

This could require a reframing of the argument by public health staff. In relation to smoking cessation, for example, it could mean focusing less on QALYs than on the impact of smoking on children. Some interviewees also emphasised that 'old fashioned advice' didn't work, that lifestyle interventions were a 'blunt tool' and, in the case of childhood obesity, the evidence base was weak. It was argued that the public health evidence, as reflected in the established evidence base for public health interventions, needed to be broadened, in order to reflect the experience of Elected Members and 'anecdotal, qualitative-type evidence that councils collect'. A 'compromise' needed to be reached across the two approaches. Members also valued officers 'targeting increasingly scarce resources at the places that really will make a difference to them politically' and it was, therefore, important to adopt a corporate approach.

Some DsPH felt that there was a lack of evidence-based leadership because local government did not respect the skills and resources that public health professionals offered. One DPH reflected that leadership authority in local government arose from having 'teams of 100 people you were directing'. Another spoke of a decision to place some selected public health services under the leadership of another directorate, rather than awarding leadership to someone with specialist training. However, another DPH felt that:

*the worst thing anyone could do as a director of public health is move into a council and be all the expert, because that is not how councils operate.*

#### **6.6.6 Scrutinising public health outcomes**

Public health outcome data were regularly reported to HWBs and Scrutiny Committees. National surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), showed a majority of respondents (59% (in 2015) and 61% (in 2016)) considered Scrutiny Committees as actively scrutinising public health outcomes.

While Scrutiny Committees were generally recognised as effectively scrutinising public health outcomes, interview data revealed a complex picture. There were differences between sites over which Scrutiny Committee was considered relevant for public health. This was not always the Health Scrutiny Committee, which might be largely focused on the NHS and integrated care. In only one of the case study sites was public health included in the title of the Scrutiny Committee. Moreover, topics could be delegated from health to other Scrutiny Committees (such as the Scrutiny Committee for children and young people). One

example of this was the possible closure of combined tuition and midwife support for pregnant teenagers, which could be referred to education or to health scrutiny. In one of the sites, the budget was scrutinised through three separate Scrutiny Committees (for children, health, performance and finance) as well as through the usual routes of cabinet and council. Leisure or sustainable development committees could also consider public health issues, depending on the scrutiny arrangements in place. While Health Scrutiny Committees could focus on public health targets included in the JHWS, for example, the breadth of public health (and dispersal of the public health budget and public health staff) meant a wide range of Scrutiny (or Select) Committees could potentially be involved. The DPH could, therefore, need to attend a range of committees and the breadth of indicators included in the PHOF might not be reflected.

This raised wider questions over how system-wide public health-related activities across directorates were to be routinely scrutinised and the level of contact between Chairs of Scrutiny Committees and DsPH (which varied from frequent to annual meetings). In one case, the breadth of the public health agenda had been considered from a scrutiny perspective and in the early period of transition, Elected Members (not limited to Members of the Health Scrutiny Committee) had been involved in order to foster understanding of broader reach of public health outcomes. This reflected the extent to which the public health team in this site had established public health-related programmes of work in each directorate that they could influence and possibly help fund.

In general, matters for Scrutiny Committees were brought to the attention of Elected Members by residents but, in one of the sites, there had been minimal scrutiny of public health issues, as no issues had been raised. In another, it was argued that scrutiny would be limited to local authority priorities, rather than focusing on indicators, such as those included in the PHOF, and in another, that more support was needed for Elected Members in this area. In contrast, some sites demonstrated a proactive approach, with discussion of delivery and effectiveness of key public health strategies, including for obesity, physical activity and drug and misuse. There was, therefore, a marked contrast in the extent to which Scrutiny Committees adopted a proactive role in considering public health outcomes, premature mortality or cross-directorate approaches to public health.

Specific issues discussed by Health Scrutiny Committees in case study sites included:

- Changes in public health staffing;
- Sexual health services;
- Breast feeding
- Falls;
- Mental health and self-harm;
- Mental health in custody;
- Loneliness;
- Food banks;
- Outcomes for re-commissioned drug and alcohol services;
- Strategies for addressing obesity and alcohol misuse;
- Physical activity;
- Health inequalities;
- Causes of premature mortality;
- Exercise on prescription (including visits by Members to GP practices);
- Transfer of health visitors to the local authority;
- Health checks.

There was criticism by some interviewees of the minimal extent to which the public health budget was scrutinised in their sites - less rigorously than scrutiny by local authorities of the NHS budget, for example. A CCG interviewee contrasted scrutiny of the PHOF with that of the Better Care Fund, with the latter monitored through regional teams, with clear targets and outcomes. This interviewee argued that if such an approach was applied to particular public health targets, spend would be protected. He noted:

*If what were to happen after 2018 is that there was to be, say, more hierarchical accountability to the centre for delivering an overall public health target, then you could see that there would be more likelihood of a preservation of public health spending. If there isn't, then I would imagine that the spending will be, to use 'savage' is the wrong word, but I think there would be significant reductions in the public health budget if the ring fence was taken away.*

### **6.6.7 The importance of trust and relationships**

Many interviewees from sites where leadership was mainly collaborative spoke of the importance of trust between partners. Examples included trust between local authority directors, who spoke of sharing resources and even undertaking additional work to help achieve others' priorities, and trust between Elected Members and DsPH, where decision-making authority was delegated. Examples also included VCSE sector interviewees, who spoke of being trusted partners in the pre-tender process, helping to design solutions, or of being trusted to undertake pilot projects with no clear outcomes and so helping to lead innovation.

In contrast, other interviewees spoke of relationships which were not based on trust in relation to the use of the budget, for example. There were a number of sites where the VCSE sector was excluded from the HWB and from the pre-tender process. References were made both by some Members and local government officers about the VCSE sector being overly expensive, not engaged with local communities and adversarial; all suggesting that the VCSE sector was not viewed as a trusted partner.

However, there did not appear to be a clear link between an authority's leadership and the decision to formulate agreements on contracts rather than on trust. One site, which showed a high level of collaborative leadership both before and since the public health reforms, had a system of service level agreements which were intended to embed a public health ethos across directorates and were widely accepted. Some VCSE sector interviewees felt that the more rigorous commissioning arrangements within local government promoted trust, engagement and participation. A number of DsPH had referred to the bureaucracy of local government, but possibly these examples illustrate both that trust cannot be contained within a written contract, and that such contracts can sometimes lead to greater transparency and openness, which actually generate trust.

As previously discussed, the public health reforms had led to reorganisation which had a disruptive and sometimes damaging effect on networks and relationships. Regardless of the structures and processes adopted by individual areas, there was a level to which successful leadership was dependent on trust between individuals. One VCSE sector interviewee concluded that ultimately this was 'down to individuals who want to make it work'.

### **6.6.8 Being more than leaders of public health**

The Health and Social Care Act 2012 gave leadership responsibility for public health to local government. However, local government has statutory responsibilities for many other areas

of public life which influence the context in which priorities are agreed. Competing priorities were discussed by many interviewees, such as healthy eating and priorities on town centre economic development or healthy lifestyles and wider determinants of health.

Despite the commitment which Elected Members and officers exhibited for fulfilling their public health leadership role, one Member did observe that public health was 'quite a way down the hierarchy' of local government concerns, partly because it represented a very small part of the local authority's total budget. Although interviewees were able to articulate thoughts on the main public health challenges that, as leaders, they need to address, they did not say how this responsibility would be fulfilled given a host of other local government responsibilities.



## 7. Strengths and limitations of the study

While each element of the study has its own strengths and limitations, the strength of the study as a whole derives from the combination of qualitative and quantitative methods. Results from four national surveys, for example, provide a national perspective for interpreting results from the detailed fieldwork analysis. Elements are discussed separately below.

### 7.1 Fieldwork in 10 case study sites

Strengths of the fieldwork element of the study include the participation of 10 case study sites where the local authorities involved met the selection criteria, and the engagement of 111 key stakeholders across first and second phase fieldwork. Authorities were drawn from all regions in England, apart from the North East, included unitary and multi-district authorities, and varied in terms of size of population, deprivation levels, ethnicity profile, rurality and political control. Most authorities were aligned with a single CCG, but four had links to multiple CCGs. While the number of case study sites is small – 10 out of a possible 152 – fulfilling our selection criteria ensured that we reflected a wide range, thereby increasing the potential relevance of our findings. Moreover, most local authorities are facing similar financial challenges, pressures to do ‘more with less’ and to pursue greater integration.

Fieldwork provided rich qualitative data for the research questions related to each of the three workstreams. It demonstrated how preventive services are being re-commissioned according to a social model, aligned with local authority services and priorities and integrated with broader changes across health and social care. It also highlighted emerging themes relevant to the future development of public health in a local authority context. These included: changing narratives for health inequalities: how prevention and evidence are being understood and prioritised in a context of local democratic accountability: and shifts in the public health workforce.

There are, however, a number of limitations. First, local authorities are inevitably varied and distinctive and while this variety can be interpreted as a strength, reflecting local flexibility and innovation, it also limits the extent to which we can generalise from our findings. Ethical requirements to preserve anonymity also work against detailed contextual information or the highlighting of good practice.

Second, local authorities differed in their involvement with (and commitment to) public health priorities prior to 2013 and this limits the extent to which it is possible to identify the distinct contribution of the public health reforms. The organisational and accountability arrangements and responsibilities of public health staff also vary by authority and the transition has been managed in different ways.

### 7.2 National surveys of DPH and CCG members of HWBs

Two national surveys were carried out one year apart. They were designed to address the main research questions of the study, exploring views over the deployment of the public health budget, commissioning and provision of public health services (with particular emphasis on adult lifestyle services and childhood obesity), innovative practice, the public health leadership role of local authorities and the working of the public health system. The surveys provided useful information on each of these aspects and, in particular, respondents provided extensive comments which were the subject of qualitative analysis. The initial

survey formed part of a wider scoping phase of the study, and was also intended to inform case study research.

The main limitation concerns the low response rate for each survey, especially for CCGs. Survey 1 had a response rate of 20.7% (28/135) for DsPH and 7.2% (11/152) for CCGs. The response rate for Survey 2 was 23% (30/133) for DsPH and for CCG representatives it was 4% (6/152). Out of 152 local authorities, 23.7% (36/152) responded in 2015 and 22% (34) in 2016. Nine local authorities responded to each survey. The low response rate for the surveys means that the findings cannot be interpreted as a measure of change.

There is a risk that our findings are biased – although we can neither prove nor disprove this. For Survey 1, we compared the characteristics of responding and non-responding local authorities, and found they were similar in terms of their population sizes, deprivation levels, and spend on public health. However, responding local authorities had a higher proportion of people of white ethnicity, and a higher proportion of people living in rural areas. Although all types of local authority were represented, responding authorities were more likely to be unitary authorities or shire counties than were non-responders. It is, therefore, possible that the challenges faced by metropolitan or London borough councils are understated by our survey. Findings should therefore be viewed in this context and not used as a basis for generalisation. In order to avoid misleading extrapolation from results, we include in the full research reports, numbers of respondents for each figure and the actual numbers for both CCG and DPH respondents where comments are reported.

Nonetheless, the surveys provide snapshots at a yearly interval of a larger group of public health stakeholders than those involved in the case studies. As such, responses can be viewed as adding weight to, or contextualising, findings and possibly challenging others.

### **7.3 National surveys: (a) Healthwatch and VCSE members of HWBs and (b) VCSE organisations involved in health promotion and prevention**

As not all HWBs have membership from the VCSE sector, it was decided to carry out two national surveys, one of Local Healthwatch and VCSE members of HWBs (Survey 1) and another of VCSE organisations involved in health promotion and prevention (Survey 2). There was a degree of overlap across survey questions which allowed for comparison. There are also some overlaps with the national surveys of DPH and CCG members of HWBs, described above.

Strengths of the surveys lie in the relevance of the topic area, the breadth of the VCSE sector surveyed and the ability to compare different perspectives across the VCSE sector and local Healthwatch. Surveys were piloted and were developed with input of a member of the project team (JS) who is a VCSE representative. All regions of England were represented in Survey 1 and 6 out of the 9 regions in Survey 2. Open questions were a particular feature of the latter survey and details of 62 preventive projects were highlighted by respondents. Through qualitative analysis of the detailed comments received across both surveys, a picture emerged of the influence of Healthwatch and the VCSE in commissioning and providing preventive services, which was further explored through fieldwork.

The main limitation, however, is the low number responding to each survey (34 respondents for Survey 1 and 39 for Survey 2). While it is difficult to identify the response rate for Survey 2, as the number of VCSE organisations involved in preventive activities is unknown and the survey was cascaded through various networks, the response rate for local Healthwatch (14%) for Survey 1 was disappointing. This means that the analysis is descriptive and exploratory and we are unable to generalise from the results. In order to avoid misleading

extrapolation from results, we include, in RR3, numbers of respondents for each figure and where we compare views of Healthwatch and VCSE sector members of HWBs we reiterate the total numbers for each group.

It should be emphasised, however, that these two surveys formed part of the scoping phase of the project, and helped inform research instruments for field work. Survey topics are explored in more detail across case study sites, which include interviewees from Healthwatch, VCSE members of HWBs and representatives from the VCSE sector locally, if these are not formally represented on HWBs.

#### **7.4 Identifying impact**

For the study as a whole, identifying impact is made more complex due to three main factors. First is the extent of historical joint working and, therefore, the extent to which the reforms constituted a change, i.e. identifying the 'added value'. This was particularly the case for areas with stable and long-standing joint working, community development approaches involving public health teams, joint commitments to addressing health inequalities and where local authorities had already developed an identity as a 'public health authority', with a commitment to preserving this ethos as far as possible, despite austerity. Interviewees pointed out that many relevant activities were independent of the reforms: they were more about the priorities of a particular local authority and of the former PCTs.

Second is the difficulty of assessing the impact of the public health reforms in isolation from reductions in the public health budget and reduced funding to councils since 2010. The concurrent and continuing financial restrictions in local authorities, in conjunction with the in-year (2015) cut to the public health grant, were seen as limiting the potential of the reforms - a factor that has been widely recognised and is also reflected in the six research reports for this project.

Third is increasing integration of public health within operational and management structures of the local authority. To the extent that public health is fully integrated, its separate contribution becomes difficult to identify. As discussed earlier, where public health teams are dispersed across relevant directorates and integrated commissioning and information resources are in place, the 'added public health value' of the transfer can be difficult to assess.

#### **7.5 Data limitations for assessing spend and outcomes**

Three years of data were available, which is likely to be too short a period to reliably identify or attribute any effects. A longer panel is preferable if the aim is to explore causal relationships.

In the analysis of NHS Health Checks, only local authority level data were available: to assess the impact of health checks on health inequalities, data at ward level or at individual level would be needed.

In the analysis of childhood obesity, multilevel models would ideally be used to investigate pupil-level data from the NCMP. These analyses facilitate adjustment for individual-level factors driving obesity, allowing the local authority effects to be separated out. However, over 8% of pupil records had been suppressed to protect anonymity. The impact of this disclosure policy was large for some authorities and negligible for others. Analyses of local authority level effects, such as spend, are consequently biased and the dataset is effectively unusable for informing local authority practice and policy, or for interrogating local authority performance. Our recommendation for an alternative disclosure solution is to add a new

category: underweight or healthy weight to the NCMP. Local authority codes could then be linked to all pupil records. This would protect against de-identification whilst permitting analysis of all cases instead of a (biased) subsample, and would enable a more robust analysis of the influence of local authority commissioning on childhood obesity.

## 8. Results and policy implications

This section summarises results from the study and indicates policy and research implications (in bold/italics) which arise from these results, where relevant. It begins by summarising views over advantages and disadvantages of the reforms (8.1), before discussing results by workstream (8.2) and in relation to innovation (8.3). It then indicates changes in orientation, with potential longer-term impacts on the public health function in local authorities and which may pose risks as well as benefits (8.4).

### 8.1 Advantages and disadvantages of the reforms

In order to provide an overview, we asked national stakeholders (RR1) and interviewees in case study sites (RR5) for their views of advantages and disadvantages of the reforms. In second phase fieldwork, we explored whether views had changed.

Interviewees cited more advantages than disadvantages and many considered there were no disadvantages. Public health teams could potentially influence a wide range of plans and strategies and the community leadership and place-shaping role of local authorities meant that they could shift their focus from health as part of a health economy to a place-based approach to health, helping to 'shape the place as well as the communities that it's serving' (Executive Director). This was linked to involvement in broader public service reform and in promoting public value. This shift in emphasis from commissioning lifestyle services to a 'whole system' approach was particularly emphasised in second phase fieldwork and contrasted with the former role of public health in the NHS, where some interviewees considered that it had 'lost its way', focusing on downstream lifestyle services and healthcare. The irony of the NHS emphasis on prevention post the reforms, as reflected in the NHS 5YFV (2014), was not lost on interviewees.

A further advantage was the connection of public health teams to Elected Members and, therefore, to local communities and community networks. Most VCSE sector interviewees also commented on wider stakeholder engagement, increased co-production and on how the profile of the sector and of partnerships had been raised. Where community development had been prioritised by public health teams in the former PCTs, relocation had reduced duplication and allowed for joined-up commissioning with the voluntary sector, using pooled resources.

Integration of children's services was widely welcomed and public health teams were often involved in commissioning these services, including CAMHS. A focus on children's services served to align local authority priorities with established public health priorities, reflected in the Marmot principle to 'give every child the best start in life'. It was noted by some interviewees that close working across public health and children's directorates had not been the case previously and the reforms had, therefore, made a difference, not least in relation to the quality of information and data. Proximity of senior managers and 'who you rub shoulders with', were considered important for developing such relationships.

There was further involvement in social care and 'wellbeing' services, although 'wellbeing' in this context often referred to prevention of hospital admission or early discharge for vulnerable groups. Providing community support, often through volunteers and in collaboration with voluntary organisations, was seen as crucial for managing flow through the 'front door' of social care. In some authorities, public health teams were seen as playing a key role in these areas, including responsibility for the preventive elements of the 2014 Care Act.

Local authority service directors often highlighted benefits of public health teams in terms of their data skills, knowledge of the evidence base, help in targeting services and increasing awareness of health inequalities, and bringing a 'new way of thinking, in a rigorous way'. Other directorates had been encouraged to 'own' the JSNA in some sites, broadening it to include issues such as child sexual exploitation and the needs of children in care.

Finally, procurement skills in local authorities were praised and cited as an advantage of the reforms, leading to improvements as preventive services were re-commissioned.

There were also disadvantages, compounded by financial stringency. The greatest disadvantage highlighted by interviewees was the confluence of austerity with the transfer of public health responsibilities. Austerity was described as a major barrier to commissioning for public health outcomes across a local system, 'derailing' the reforms, especially in inner-city areas. Local authorities were seen as a 'high risk' environment for public health, given continuing cuts in their overall budgets: the public health budget could easily be reframed in line with local authority priorities and statutory commitments. Public health funding was considered more likely to be squeezed 'disproportionately' than in the NHS, which had more financial protection, hence concerns about the loss of a ring fence, however permeable in practice. The reforms were also described as reducing the emphasis on the public health evidence base in the light of other priorities. Concerns were also expressed over a potential loss of substantial NHS investment in health visitor numbers prior to transfer and a change from universal services and national standards to services which were locally agreed and targeted (as had already been the case in some sites, following transfer of school nursing services). There was concern that the NHS investment would be 'stripped out due to austerity measures' after an initial period, and that changes were not being 'adequately scrutinised'. VCSE sector interviewees cited examples of organisations losing public health funding and most were concerned that continued austerity measures would be damaging to the sector.

Fragmentation in commissioning preventive services, including immunisation and vaccination, was highlighted by a number of interviewees, given the separation of commissioning functions across CCGs, NHSE and the local authority. Some CCG interviewees considered that a better balance was needed locally across action on wider determinants of health and prevention in primary care, which had been weakened by the reforms. Data sharing posed problems, with DsPH not having access to the NHS data that they needed (e.g. immunisation rates at GP practice level) although these issues were not necessarily attributed to the reforms. In some sites, health protection arrangements were also described as 'fragmented' with a lack of capacity and of 'boots on the ground'. It was questioned, for example, how serious incidents were being defined in the new system. However, in other sites, interviewees described benefits including access to residential homes, where they could encourage contingency plans and support infection control.

Some interviewees described a combination of advantages and disadvantages. For example, it was argued that austerity had also led to a greater emphasis on effectiveness, targeting of services, commercialisation of services provided by the local authority (such as healthy school meals) and streamlining (for example, through 'lateral linkages' of data systems). It had also promoted 'whole systems' thinking and a move away from what some interviewees described as 'a dependency culture' towards a greater emphasis on community resilience.

While HWBs were often welcomed, it was less clear how they fitted into local authority decision-making processes. The ring-fenced budget was seen as protective by many, especially over the shorter-term, but was also criticised by both local authority officers and DsPH in the second phase for its lack of flexibility and for promoting an ‘us and them’ mentality. Aspects of the reforms also had unintended consequences. Public health teams being embedded throughout the local authority was seen as a major potential benefit of the reforms but could serve to diminish their visibility and ‘the value placed on specialist knowledge to fulfil this role’. Moreover, while location in a local authority meant that public health teams had more freedom to comment on national policy, the same did not apply to policies espoused by the local governing party. Interviewees expressed uncertainty over the future role of the public health profession as well as highlighting positive aspects of a broader public health workforce and ways this could be further developed. In some sites, interviewees reported less emphasis on the evidence base for public health interventions following the reforms, but a greater focus on local context and priorities.

Almost three quarters of Local Healthwatch and VCSE members of HWBs who responded to the national survey (n=34 (RR3)) supported the public health reforms, but only a minority identified improvements arising from the reforms for public involvement in commissioning, co-design of services or commissioning services from the VCSE sector.

## **8.2 Results and policy implications by workstream**

Results and policy implications are summarised for three workstreams which reflect new responsibilities arising from the reforms: the public health budget; commissioning public health services; and the public health leadership role. There follows a discussion of whether the reforms have led to innovation and a review of factors which are likely to influence the future development of public health services. As mentioned above, text in bold/italics highlights policy/research implications arising from analysis of results.

### ***Impact of new responsibilities: (1) the public health budget***

As a local authority budget, the public health ring-fenced budget was often aligned to local authority priorities and used to fund services where cuts could affect health outcomes. The budget could be ‘rebadged’ under ‘wider determinants of health’, but the extent of this varied as did the degree of control over the budget by the DPH. By second phase fieldwork, the budget was increasingly described as a local authority budget, managed by other directorates with public health commissioning included as part of centralised commissioning arrangements. The importance of the ‘totality of the resource’, while recognised throughout the study, was further emphasised. However, some interviewees questioned whether the cost-effectiveness of changes in how the budget was deployed was adequately considered. Budget (and staff) absorption across different directorates could make audit more difficult.

***Costs and benefits of shifts in the use of the budget across different directorates required further development and local monitoring, to include how the budget could be used to best effect across local authority directorates to promote public health outcomes.***

The public health budget had been used as a catalyst to promote consideration of additional public health outcomes across directorates, (involving Elected Members with a range of portfolios), for leveraging funds from CCGs or for attracting national funding.

***How the public health budget has been used as a catalyst could be further evaluated and disseminated.***

The in-year cut to the public health budget (2015) was roundly criticised and by second phase fieldwork, the impact of this and other cuts to local authorities included: reducing and targeting lifestyle services; reductions in public health staff; stopping funds for district public health activity; renegotiating reductions in existing contracts; prioritising strategic development through public health teams rather than focusing on their commissioning role; prioritising different public health services (or stopping some services altogether); assessing cost-effectiveness (or simply aiming for 'harm reduction'); and continued 're-badging of services'. Most often cited as inadequately funded were exercise initiatives and services for alcohol misuse and obesity. HWBs rarely discussed how to prioritise across budget categories or the costs and benefits of shifts to other directorates.

***The in-year cut and ongoing reductions to the public health budget were having effects on services and staff capacity. Minimum requirements for preventive services therefore needed clarification.***

Most interviewees were in favour of the ring fence (with the important exception of most local authority service/executive directors) as a form of protection, especially over the shorter-term, and as a way of promoting accountability. There was a risk of marginalisation if both the ring fence and mandatory functions were removed. It was also widely recognised that the ring fence was 'permeable' and that the main focus should be on outcomes.

***While the public health budget has its weaknesses, it can provide data relevant for assessing variation in spend in relation to public health outcomes across authorities with similar needs.***

***The extent to which the public health budget is intended to promote accountability for providing specific services could be clarified.***

Less than half the respondents (42%) to the 2016 survey of DPH and CCG members of HWBs (n=36) favoured retaining the distinction between mandated and non-mandated services (although numbers are small) and most of those who commented were critical of the selection as not reflective of the evidence base nor of services of greatest importance. There was also concern that mandated services would become the only focus for public health spending. Moreover, mandated services (such as Health Checks and the NCMP) were described as about 'measurement rather than action'. Interviewees also reflected a range of views: some did not consider it a helpful distinction, given variation in how authorities met mandatory requirements and emphasised the importance of room for manoeuvre and local relevance. The choice, evidence base and status of mandated services were further questioned. However, the distinction could protect essential services that were not high profile or might not be viewed as 'vote winners' but providing mandated services without the protection of a ring fence would be difficult. A broader issue was the primacy of local authority statutory duties and the relative status of public health mandated services which were less clearly specified and mandated rather than statutory.

***Mandated services required refreshing. Minimum levels of services for defined populations and the extent of acceptable local flexibility needed clarification.***

As well as criticising current budget cuts, interviewees also voiced concern over the allocation formula, the relevance of public health budget reporting categories and future plans for funding public health services. Budget categories did not provide an accurate



picture of public health spend and it was often unclear what should be included under the reporting categories (e.g. for health protection) or how it should be costed. Many services fell outside the categories which, in addition, did not reflect overall local authority spend.

***The allocation formula could be reviewed to assess its relevance for demand-led services and services used by younger age groups.***

***Further assessment was needed over the impact on health inequalities of a shift towards funding of local authorities through retention of business rates.***

***Impact of new responsibilities (2): commissioning preventive services***

Local authority procurement processes were described as resulting in efficiencies, more detailed outcome-based specifications (including for social outcomes), greater targeting, use of incentives (in a few cases), more outsourcing and a wider diversity of providers through arrangements for regular review and re-procurement. Tendering processes were standardised and increasingly unified in a single commissioning facility for the local authority and scrutiny was described as more robust.

***There were lessons to be learnt by the NHS from local authority procurement processes.***

***Procurement systems needed to be proportionate to the size of the grant and contractual complexity should be reduced, where possible. This was of particular importance for smaller VCSE organisations with local knowledge.***

By second phase fieldwork, most sites had already re-commissioned substantial areas of spend in the public health budget, that is, sexual health services and drug and alcohol services, and had either completed or were in the process of re-commissioning healthy lifestyle services. As preventive services were re-commissioned they could incorporate a social model, peer-based approaches to changing behaviour, social prescribing and greater responsiveness to community needs and experience. Interviewees in some sites described improved outcomes from re-commissioned services, such as sexual health services and substance misuse services.

***Comparative analysis of outcomes across local authorities for re-commissioned preventive services could help extend the public health evidence base and promote good practice.***

Over the course of the project, there was a decline in commissioned preventive services, such as smoking cessation and weight management, and greater targeting across the board, even for mandated services (such as NHS Health Checks) and universal services (such as health visiting). Weight management services were those most likely to be decommissioned.

***The decline in provision of preventive services needs to be monitored and potential impact on health outcomes assessed.***

***Further discussion is needed over the balance across universal services, self-referral and targeted services for specific preventive services.***

Changes in the provider landscape were anticipated in the reforms and surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), showed that between 36% and 44% of

respondents indicated increased involvement of local authority employees, volunteers, VCSE organisations and pharmacists for preventive services, with the largest increase (between 2015 and 2016) for VCSE organisations. Despite the role of VCSE organisations in engaging with vulnerable and underserved groups, promoting innovation and encouraging co-design of preventive services, their involvement was relatively neglected in some sites. Engagement with smaller, local VCSE organisations was variable and many contracts favoured larger organisations. Some sites favoured direct council support for community development initiatives. Only half the sites had representatives from the VCSE sector on their HWBs.

A number of changes were highlighted as enabling VCSE organisations and local Healthwatch to exert greater influence on commissioning preventive services. These included: capacity and resources; greater recognition by commissioners; more emphasis on co-design and community involvement in developing priorities; and changes in the ways that HWBs reached decisions, with greater recognition of local Healthwatch and the VCSE sector.

***There could be further dissemination of examples of successful engagement of the VCSE sector with commissioners in relation to preventive services.***

***There could be more extensive dissemination of ways in which the Social Value Act has been incorporated /led to changes in commissioning practice.***

***There could be further development within the VCSE sector for organisations to work in partnership and provide evidence of effectiveness.***

The shortage of funds for commissioning services (especially those which were not demand-led) further encouraged public health teams to focus on whole system approaches, rather than on the narrower task of commissioning preventive services. This was reflected, for example, in developing JHWSs that were broader in scope and in encouraging a public-health informed approach to commissioning across directorates, place-based approaches and in changing the attitudes and behaviour of the workforce as a whole. Examples of the latter included using a social care workforce and children's centres to encourage uptake of preventive services, leisure centre staff to provide health checks or fire and rescue services to carry out health-related activities. A focus on health inequalities and proportionate universalism could be encouraged across all local authority strategies to encourage authority-wide action.

***JSNAs could include assets as well as needs. JSNAs and JHWSs could be reconfigured to reflect the breadth of public health-related action across the local authority.***

***Further dissemination of good practice is needed in relation to improved uptake of preventive services through the development of a local authority public health workforce.***

Processes for community engagement and co-design of services were already well-developed in local authorities and there were examples of co-design influencing preventive services as they were re-commissioned, including services for emotional health and wellbeing, sexual health and drug and alcohol misuse. In some sites, Healthwatch was active in promoting co-design principles and some Healthwatch interviewees argued for greater involvement in developing plans for preventive services.

***Contracts for preventive services could include further requirements for active engagement/co-design.***

Interviewees across most sites (including CCG as well as local authority interviewees and encompassing sites with different political control) emphasised the importance of encouraging communities (of both identity and of place) to help themselves through asset-based community development. Interviewees emphasised the importance of context, looking at the needs of communities in their localities and encouraging communities to become more involved, taking more responsibility for improving health and wellbeing. This could involve volunteers and draw on local neighbourhood networks. Initiatives often combined community capacity-building with demand management and a search for innovation. However, these could sometimes take the place of local authority services, such as day centres.

***The longer-term sustainability of services provided through community groups requires further evaluation.***

Surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), indicate that for community involvement, co-commissioning and identification of underserved groups, there were changes in the direction anticipated by the public health reforms between 2015 and 2016.

Wellbeing services were increasingly integrated, bringing together under one contract a wide range of services previously provided separately, such as exercise on prescription, nutrition, physical activity, smoking or weight management.

***Models for providing integrated lifestyle services could be further explored and costs and benefits of different models evaluated.***

Moreover, the integration agenda had led to collaboration, pooled budgets and locality or neighbourhood-based teams, hubs and networks. While the predominant focus was on supporting frail older people and promoting independence, there were examples where the preventive element of these neighbourhood systems was extended through broader locality-based 'wellness organisations', providing a single access point for a wide range of services with wider determinants of health also considered. There are many models for community hubs and for the navigators/connectors/liason workers connected to them. The extent to which they incorporate preventive services varies.

***There is scope for evaluating integration of wider preventive services within community hubs.***

A major benefit of the reforms was the closer relationship between public health teams and local schools, although schools showed different levels of engagement. In relation to healthy weight, for example, some services had been re-commissioned to be delivered through school nursing contracts. In some sites, schools had implemented the 'daily mile'.

***The impact of changing services for childhood obesity towards greater involvement of school nursing services needs to be evaluated.***

***Further dissemination is needed of examples of effective engagement between schools and public health teams.***

There was a degree of concern over fragmentation and ‘fracturing’ of preventive services, such as immunisation and vaccination of school age children and sexual health services, with three commissioners involved - NHSE, CCGs and the local authority – described as a source of confusion for primary care providers. Some interviewees even considered that specific preventive services, including CVD risk management and smoking cessation might need to be protected through revising the mandatory functions or could usefully revert to the NHS as part of the pathway of care. Some treatment services were considered not to fit well into local government and the budget could continue to be eroded, leading to further fragmentation with primary care preventive services.

***Where services span different elements of the system, there are arguments for reconsidering how pathways of care can be strengthened.***

***NHSE could play a greater role in monitoring CCG performance in relation to preventive services.***

Health checks, a mandated service, provided a further example of fragmentation given that follow-on services were not always available. Sites showed different levels of engagement with the programme. At one end of the spectrum was a combination of GP provision, extensive outreach services (sometimes provided through social enterprise) and integration with healthy lifestyle services. At the other, was scepticism about the programme’s value for money and effectiveness in reducing inequalities, combined with implementation challenges due to attrition from GPs and restricted provision of follow-on services. Interviewees noted that while it was mandatory for the local authority to commission health checks, it was not mandatory for GPs to provide them.

***Given the range of views over the effectiveness of health checks, especially as a universal service, further dissemination is required of examples where targeting through primary care or through outreach initiatives has been successful.***

***National data at ward level would enable the impact of health checks on health inequalities to be assessed.***

The study also identified different approaches across sites to childhood obesity but evaluation of outcomes was less evident. There was scepticism over the robustness of the evidence base or the effectiveness of local action without changes at a national level. Data analysis of spend and outcomes was inhibited by data deficiencies.

***Data collection on percentages of overweight children could be reviewed to avoid suppression of data required for analysing the effect of spend on outcomes.***

***Further dissemination of low cost but effective initiatives is needed, including the ‘daily mile’.***

***The limits to local action need to be recognised with further national support for local action (for example, in restricting fast food outlets).***

The study illustrated changes in how health inequalities were being conceptualised and prioritised. In the NHS, there were targets for narrowing the health gap (2002-10) and extensive monitoring and performance management arrangements. PCTs were also

provided with peer support to help meet their targets for health inequalities. Interviewees commented on a relative lack of support for addressing health inequalities from the NHS since the reforms, despite it being a statutory duty. Some of the case study sites had long-standing commitments to addressing health inequalities, reflected in local authority plans, partnerships and through health inequality impact assessments, describing themselves as already a 'public health organisation' or 'early intervention council' and, where this was the case, it was argued that the reforms provided a continuity of approach. Many sites required the impact on health inequalities to be considered as part of decision-making processes.

However, many interviewees, including local authority executive directors, reflected a broader range of approaches. These included an emphasis on vulnerable children and the role of the local authority as 'corporate parent'; the shift from universal to targeted approaches, an emphasis on 'consultative' rather than on 'analytic' approaches; a reframing towards priority groups; cross-directorate approaches; and advocacy and social mobilisation. They also focused on those most likely to suffer from inequalities over the longer-term (such as children identified as not ready for school), rather than on evidence for interventions likely to lead to reductions in premature mortality over the shorter-term. In one site, it was pointed out that differences in age and deprivation profiles across different wards meant that less attention might be devoted to areas of disadvantage, as they were the areas 'that don't vote for the majority party and this administration'.

***Examples of how proportionate universalism can be encouraged across all council services could be reviewed.***

***Additional support for addressing health inequalities through comparative analysis and peer support (as was offered in the NHS) could be considered.***

***Case studies of how health inequalities impact assessment has influenced prioritisation of preventive services and decisions across directorates could be disseminated.***

***There could be further clarity in local decision-making over timescales for reducing premature mortality.***

### ***Impact of new responsibilities (3): the public health leadership role***

When asked to define hallmarks of successful public health leadership in local authorities some commented specifically on the importance of leadership of DsPH and their teams, some on generic leadership characteristics, such as motivational skills and others on the leadership role of the local authority as a whole. Interviewees highlighted a wide range of public health challenges, including social isolation, mental health problems, domestic violence, crime and violence, needs of migrants, homelessness, lack of readiness for school and troubled families as well as issues such as obesity and health inequalities.

Embedding a public health perspective within and across directorates was a key aspiration of the reforms. Interviewees discussed how this could be promoted through greater influence of public health teams within directorates; breadth of HWB membership and debate; routine use of health and health inequalities impact assessment and, for two-tier local government areas, coordination across districts and county councils.

The 2016 national survey of DPH and CCG members of HWBs (n=36), showed that 86% of respondents reported that ways of encouraging healthy lifestyles were being considered

across local authority directorates. Second phase fieldwork further reflected this emphasis on authorities improving health in ways other than commissioning services - 'changing in a different way' - underlining the shift away from commissioning specific services towards a strategic focus. Interviewees described synergies and alignment across local authority services, such as schools, leisure and housing, while the transfer of services for under-fives also provided the opportunity to integrate public health services for children. One of the tasks for public health teams was described as to 'add value' to a wide range of local authority services.

Nevertheless, while involvement of public health staff in directorates for adult and children's services was common, there was less evidence of involvement in highways, environmental services planning or regeneration. In some sites, 'acceleration' of cross-directorate working was described, with influence over local authority strategies and plans which had not been possible previously. Second phase fieldwork showed that cross-directorate working had increased, although often on an ad hoc rather than systematic basis.

Breadth of membership of the HWB varied, as did its discussion of wider health issues. HWBs were subject to criticism in most (but not all) sites, limited by their membership, their place within the governance arrangements of local authorities and their lack of decision-making power. Integration of health and social care was often the main focus: sometimes other committees had been established to consider public health issues across directorates. Some interviewees commented on the benefits of local level engagement across CCG members and Elected Members, working below HWB level.

***The most effective ways of considering wider public health issues across local authority directorates may need further development.***

***Examples of effective local level engagement across CCGs and Elected Members could be disseminated.***

While responsibility for many public health initiatives lay with districts and some had established their own HWBs, coordination and support for district-level public health activities was very variable, complicated by travel and topography. HWB priorities did not always translate to districts and public health funding for districts had been discontinued in one site, due to cuts.

***Consider how public health action across districts, including local hubs, can be coordinated and enhanced and the appointment of district councillors with a public health portfolio encouraged.***

While a majority of respondents for both national surveys of DPH and CCG members of HWBs considered that local authority Scrutiny Committees were actively scrutinising public health outcomes, interview data revealed a complex picture. There were differences between sites over which Scrutiny Committee was considered relevant for public health. This was not always the Health Scrutiny Committee, which often focused on the NHS and integrated care. While Health Scrutiny Committees could focus on public health targets included in the JHWS, for example, the breadth of public health (and dispersal of the public health budget and public health staff) meant a wide range of Scrutiny (or Select) Committees could potentially be involved and the breadth of indicators included in the PHOF might not be fully reflected. In some sites, Scrutiny Committees adopted a proactive approach to

public health outcomes, premature mortality and cross-directorate approaches for improving health.

***Local authority Scrutiny Committees could consider how best to scrutinise public health outcomes given the breadth of the PHOF, dispersal of public health funds and the importance of cross-directorate commitment to improving public health outcomes.***

***Both longer and shorter-term public health outcomes should be identified and progress reported across relevant directorates and Scrutiny Committees.***

There were many examples of engagement of public health teams with Elected Members with the latter playing an active role in the public health agenda, especially in second phase fieldwork. Examples included: ward-based meetings; ward-based health profiles; development days; and opportunities for public health training. Some Elected Members were already public health advocates, had a separate public health or wellbeing portfolio, or communicated with Members across different political parties in their communications over public health. There were also examples of DPH annual reports being made more engaging, narrative-based and experiential, the creation of 'living databases' for JSNAs and an emphasis on clarity of communication for Elected Members, including reframing issues to more closely align with the interests of local communities.

Where a wide range of Elected Members was involved, it was argued that public health was more likely to be prioritised across the local authority. However, confusion over the spectrum of public health activities and their role within it continued to be expressed by Elected Members in some sites: views over what public health entailed in practice varied among both officers and Members. However, credibility of public health teams was *a sine qua non* for exerting influence across the local authority, otherwise DsPH could become what one DPH described as a 'lone voice' when it came to leadership of the public health system or the situation could turn into what another described as 'prevention under siege'. Other factors affecting public health leadership were differences in the relationships between officers and Members. Chief Executives also adopted different approaches towards the strategic role and purpose of public health so a change in Chief Executive could also affect the role of public health teams.

***There should be clear written guidance for Elected Members and portfolio holders on the public health responsibilities of the local authority.***

***Public health awareness could be encouraged in a more systematic way across all staff in the local authority.***

***Specialist public health portfolio roles for Elected Members could be more widely adopted and decisions of HWBs (and other relevant committees) could be communicated across all Executive Members***

***Clarity is required over the independence and role of the annual report of the DPH with further dissemination of examples where reports have resulted in wider impact and engagement.***

***Clarity is needed over the extent of acceptable variation in local plans and priorities for addressing health inequalities.***

Interviewees commented on actual and potential effects of the reforms on the public health profession, expressing uncertainty over its trajectory, future role and sustainability, as well as highlighting positive aspects of developing a broader public health workforce. Questions over role and purpose seemed continually under review, leading some to voice uncertainty over the future of public health. There was discussion of initial difficulties in transition, reductions in public health capacity, differing levels of embeddedness across the local authority, difficulties in ensuring specialist training and uncertainty over the future shape of a public health workforce.

***Clarity is needed over the minimum critical mass of specialist public health staff required to meet the aims of the public health reforms, balanced with the changing demands of the new context, and how this is to be monitored and assured.***

***Further consideration needs to be given to the training needs of the public health profession in a new context, to include new routes for specialist training. There should be further assessments of the impact of changes in the recruitment and training of public health staff.***

It was argued that public health training should take account of the new context. In some sites, there were skills escalators and clear pathways for local authority employees to be trained in public health skills. Some interviewees considered that the long-term effects on the public health profession and the public health function needed to be more carefully considered and that the next few years would be critical for public health to demonstrate its effectiveness within a local authority context.

By second phase fieldwork, the influence of STPs on the integration agenda was acknowledged. Public health teams were increasingly involved in developing STPs, including modelling their potential impact, but despite their status as the implementation strategy for the NHS 5YFV, NHS commitment to prevention was questioned. Nevertheless, interviewees commented on a renewed emphasis on healthcare public health and secondary prevention and in a minority of sites, STPs also focused on health inequalities and healthy life expectancy, which presented opportunities for improved commissioning and reorientation towards prevention and early intervention. Criticisms of STPs included the process through which they were introduced, a lack of funds for implementation and, in some cases, a move away from wider determinants of health and from the views of the public. They also raised governance issues and contributed to the complexity of commissioning, especially in areas spanning a number of local authorities. There was a mix of arrangements for accountability and audit with different regulators involved.

***More detailed information was needed in STPs on return on investment across a system. Ways of balancing risk and gain across partners/pathways of care needed to be further explored and disseminated, including social impact bonds.***

***More consideration was needed by NHSE of decision-making arrangements and timescales in local authorities.***

One DPH took a different view, insisting that public health should focus on primary prevention and the wider determinants of health: this had been reflected in a senior place-based role for the DPH in that site.



### **8.3 Have the reforms led to innovation?**

Surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), showed that areas where there was most agreement over local authority support for innovation were in facilitating cross-council working with key partners (79% (2015) and 86% (2016)) and commissioning integrated services (76.3% (2015) and 86% (2016)).

Interviewees highlighted many examples of innovation in public health, brought together in eleven elements of an innovation framework for public health commissioning (RR6), although many initiatives were context-specific and not all could be attributed to the reforms. Moreover, the parameters of what to include under the rubric of 'innovation in public health commissioning' were shifting in the context of broader conceptions of commissioning for wellbeing in the public sector.

Co-location of public health teams, combined with a programme for re-commissioning services had encouraged increased community involvement and co-production, connections across preventive and other local authority services, less emphasis on single interventions for unhealthy behaviours, greater recognition of the family and social context and the need to adapt good practice to local circumstances.

In addition to changes in traditional preventive services, there was also potential for innovation through public health perspectives being applied to traditional areas of concern for the local authority, new responsibilities for public health teams in areas such as leisure, or supported housing, and involvement across directorates, such as environment or planning, although public health involvement was less evident than in 'people' directorates.

***Examples of changes and added value in local authority services arising from public health perspectives being applied could be further disseminated.***

It is clear from the nature of many public health challenges that a combination of the elements described in the innovation framework for public health commissioning is often required. These include community engagement, actions across the wider system and the choice of providers reflecting a more holistic and contextual approach.

Analysis by site revealed differences in emphasis, in particular in the extent to which innovation in public health was explicitly promoted from Elected Member level through senior leadership and across all staff; in the role of evidence and implementation 'at scale', as opposed to experimentation and local knowledge; in communities as a source of innovation; and in the extent to which the VCSE sector was a partner in developing innovative projects. Interviewees also reflected on innovation arising from the location of public health teams in local authorities, less central control, more local flexibility, closer links with Elected Members and an increase in synergy across public health teams and local authority directorates.

An analysis of downward, sideward and upward levers for innovation showed a predominance of downward levers, including the impact of austerity and leadership. While separated for analytic purposes, levers often work in tandem and innovation is more effective where levers are aligned.

***Ways in which public health innovation has been encouraged through contract specifications, use of incentives and other local authority initiatives could be further disseminated.***

***An innovation framework for public health commissioning could be further developed and used as one route for disseminating good practice.***

Public health innovation also raises discipline-specific issues: improvement in population health may be less about innovation in particular services than about a commitment to put health first, address social determinants of health and health inequity and implement essential public health services at scale.

***Innovation in public health needs to take account of equity and population-based approaches as well as innovative approaches to specific preventive services.***

The question remains whether the momentum for public health innovation is maintained as the changes instigated by the reforms become the norm.

#### **8.4 Reframing public health in a new context**

It became apparent over the course of the project that shifts in key concepts and drivers of public health activity could exert an important influence on the future development of public health and that the significance of these shifts was likely to vary by authority. These include: a shift in the role of public health teams from commissioning services to influencing and advocacy; emphasis on data skills rather than commissioning responsibilities or wider influence; and alignment with local authority priorities, including an emphasis on demand management. In addition, authorities varied in factors underpinning decision-making, such as views over timescales required for improving health, the role of individual responsibility, the nature of evidence and assessments of return on investment. There were also differences in how prevention, wellbeing and health inequalities were described.

##### ***From public health commissioning to 'commissioning for public health'***

Public health services and the public health budget were increasingly discussed in relation to local authority commissioning priorities (notwithstanding reporting arrangements to the DCLG). While some interviewees largely supported the ring fence, others considered it limited room for manoeuvre and separated public health from the rest of the authority. If public health staff were considered mainly in relation to the transferred public health budget, their role in relation to wider public health challenges could be reduced.

Where public health staff and the public health budget were dispersed across different directorates, commissioning responsibilities usually formed part of the remit of the relevant Executive Director or commissioning was carried out as part of a centralised commissioning facility, a trend that was more marked in second phase fieldwork. One implication for public health teams, again particularly evident in the second phase, was increased emphasis on the strategic, influencing and advocacy role across local authority directorates and with Elected Members – sometimes linked with the promotion of public value and the transformation of the public sector in general, rather than with transformation of public health. Conversations were less about a public health commissioning system than what was described as 'a commissioning system with public health included in it'.

Influence over wider determinants of health was a major reason why local authorities were considered the 'natural home' for public health teams and the public health function. However, there was a degree of mismatch between the main advantages of the reforms in theory and how they were described in practice. As they discussed the specific contributions

of public health teams, Executive Directors particularly emphasised health intelligence, data and needs assessment, increasingly applied across a range of local authority services, rather than commissioning responsibilities or wider influence. This was less the case for sites which described themselves as having a long-standing concern with public health and health inequalities.

#### ***Alignment with local authority priorities and managing demand***

By second phase fieldwork, public health teams were mainly engaged in 'People' directorates, (although in some sites, teams were dispersed across all directorates). This was reflected in organisational and accountability arrangements. Prevention of demand for statutory services and 'downstream' approaches were increasingly evident. One corollary of this was the emphasis on managing demand for social care through promoting independence and self-care. One Director noted they would be looking to public health to 'mitigate the worst effects of further cuts in social care' and another interviewee argued that public health needed 'a different stance on what public health is and what it does'.

Emphasis could be placed on preventing pressures on various 'front doors'- of hospitals, social care and children's care facilities - focusing on needs of the most vulnerable and on particular client groups and preventing or delaying the need for statutory services. In some sites, related services were funded by the public health budget and managed through the public health team.

A combination of STPs, the wider agenda for integration of health and social care, the preventive requirements of the Care Act and the obligation for local authorities both to stay within their budgets and manage increasing demand for adult social care framed the activities of many public health staff. This point was made explicitly by a number of Executive Directors and some DsPH. The directorate in which public health was located could influence the ways in which the budget was spent and there were arguments by some DsPH for greater 'neutrality' for public health, so it could engage across the board.

#### ***Factors underpinning decision-making and priority-setting in public health***

The transfer of public health into local authorities provided an opportunity to influence across a 'wider stage' and to work with Elected Members, drawing on their knowledge of local communities. In some sites, this worked well from the outset, especially where there had been long-term collaboration, while in most other sites, there had been positive developments over the course of the study. Interviewees highlighted a number of differences between the respective environments of the NHS and the local authority.

#### ***'Geologic' timescales***

Timescales for influencing longer-term health outcomes were described as 'geologic' by one Strategic Director, given the immediate and pressing demands on councils, the requirements of statutory services, the current financial situation and the local priorities reflected by Elected Members. A number of interviewees argued that local authorities were more tightly focused on financial accountability within shorter time frames. However, evidence-based interventions adopted by the former PCTs for reducing health inequalities, such as smoking cessation, were selected for their effectiveness within a relatively short 10-year period. This suggests that the question of timescales for different types of public health interventions requires further scrutiny in a new context. Planning over the longer-term was described as more straightforward in sites without rapid turnover of Elected Members or changes in political orientation.

### *Citizen and state responsibility*

Executive Directors made the connections between the need to redefine and transform the relationship between the individual and the state, thereby reducing demand for care, encouraging communities to help themselves and creating a less 'dependent' culture. While this was often linked to lack of choice in a context of austerity, the link was also made with the benefits of empowerment and developing local resilience. There was also a view that local authorities should prioritise the needs of those unable to take responsibility for their health. The role of councils as 'corporate parent', for example, meant prioritising needs of the most vulnerable, such as children in care, rather than what were described as choices made by adults. This was, in part, a reflection of political discourse in authorities over the extent to which the state should intervene in the lives of citizens. However, regardless of political orientation, all sites showed interest in asset-based community development. Some were at an early stage while in other sites initiatives predated the reforms. A blend of the search for community relevance and sustainability, ground-up innovation and demand management, this approach was contrasted with a 'top down' public health culture, sometimes described as promoting dependency and not addressing the 'breadth of what underpins health and wellbeing'. Asset-based approaches also reflected shifts away from single interventions to community projects incorporating a range of activities – such as gardening, dementia day care, reduction in social isolation and support for mental health problems. The emphasis on place-based approaches also supported initiatives which promoted community wellbeing.

### *The nature of evidence*

Different approaches to evidence within a local authority context have been identified in previous research (Lorenc et al., 2014; Hunter et al., 2016; Marks et al., 2016). Our study also found clear tensions over what constituted evidence, its role in decision-making within a context of local democratic accountability and how evidence should be presented to influence decision-making. This was contrasted with the role of evidence as presented by professionals within the NHS. While interviewees recognised the contribution of a public health evidence base and statistical analysis, there was increased emphasis on the views of Elected Members and on what was important to electorates in framing priorities.

Scepticism over the level and type of evidence needed to develop initiatives was expressed. Elected Members felt they understood the needs of their communities and were elected to reflect their priorities. These needs and priorities might or might not tally with priorities implied by evidence of the effectiveness of public health interventions, as presented by a public health team. It was also argued that the evidence base, rigidly defined, could hamper innovation and the ability to fund ideas coming up from communities. Furthermore, effects were often long-term, which could jar with immediate and short-term priorities and might not feed into factors that could ensure election. In some sites, evidence-based lifestyle interventions, such as smoking cessation, were less favoured while in others, smoking cessation and wider tobacco control measures were prioritised. Some sites focused on weight management while in most of the sites, these services were the ones most likely to be discontinued. A more downstream role for public health teams could displace primary prevention: in one site this had been resisted, with the focus resting on primary prevention and place-based approaches.

By the time of second phase fieldwork, there was evidence of a more sanguine approach among some public health interviewees to the decline in lifestyle services. They were described as a 'blunt tool', for example, unlikely to address inequalities due to differential take-up, while system-wide and place-based approaches could be more effective over the

longer-term. Scepticism was expressed over the evidence base for public health interventions, particularly for childhood obesity, given the importance of national level interventions, and what was described as lack of evidence for long-term effect for specific local interventions.

#### *Broadening the cost-effectiveness debate*

While evidence of effectiveness for smoking cessation services was clear, its cost-effectiveness in a local authority context was considered less clear. It was argued that timely social intervention (for example, for young people leaving custody or leaving care) or early intervention for vulnerable children showed far greater return on investment and had an impact across the range of health inequalities – whether social, economic, health or educational. Therefore, one of the impacts of a local authority context for public health was a broader approach to assessing return on investment, to include social return on investment within which the cost-effectiveness of public health interventions would be considered.

#### ***Social return on investment requires further consideration in the context of prioritisation across directorates and the wider system.***

Some interviewees noted the lack of financial incentives to promote prevention. For example, it was argued that some of the benefits of smoking cessation would accrue to the NHS, rather than addressing the immediate budget pressures of local authorities. Interviewees commented on the importance of balancing gain and loss through the use of social impact bonds across a particular pathway of care, or wider partnership approaches to cost-effectiveness across a whole system. It was emphasised that the economic arguments for prevention needed to be continually reinforced at a local level.

#### *Defining wellbeing, prevention and health inequalities*

Terms such as 'prevention', 'wellbeing' or 'wellness services' were defined in different ways. For example, wellbeing services could refer to services designed to prevent hospital admission or provide post-discharge support, whereas integrated 'health and wellbeing services' could refer to: (1) health and social care services; (2) integrated lifestyle services; (3) a development of the latter, where action on social determinants of lifestyle choices was integrated with lifestyle services. Shifts in definition could be reflected in what was considered as the function of public health in local authorities, the core tasks of public health teams and the nature of the specialist role. This could be more significant where public health was not a separate directorate, as departmental integration could potentially weaken a sense of identity and the professional skill set.

In the national survey of VCSE organisations involved in health promotion and prevention, (n=39) where respondents were asked to highlight preventive activities, there was little congruence between the preventive activities highlighted by VCSE respondents and the public health budget reporting categories. Prevention was broadly defined and encompassed services ranging from prevention of hospital admission to the promotion of mental health in vulnerable groups. Services designed to address risk factors, such as smoking, or social determinants of health across directorates of the local authority, formed a small proportion of the activities described, but mental health was an important focus in almost half the projects highlighted. Survey respondents described little involvement in health checks, obesity, sexual health services or smoking cessation, and for preventive services, there was an emphasis on methods of engagement where advocacy, peer support and volunteering were often combined.

These findings tally with the LGA 'Public Health Opinion Survey' (LGA, 2015a) which showed that 79% of respondents wanted the council to do more on mental health while less than 30% of respondents considered more needed to be done in relation to sexual health (19%), smoking (29%) or drug misuse (17%).

It is likely that different understandings may influence the parameters of health, wellbeing and public health debates in HWBs, as well as the potential role of the VCSE sector in promoting prevention.

***There are arguments for making definitions of prevention explicit to avoid ambiguity or lack of attention to the spectrum of public health activities and to reflect realistic timescales for improvement of public health outcomes.***

Reducing premature mortality through addressing inequalities in health and contributory lifestyle factors was the predominant approach adopted by the former PCTs and the study illustrated changes in how health inequalities were being conceptualised and prioritised. As discussed earlier in this section, while there was a degree of consistency in the NHS over how health inequalities targets were to be met, including narrowing the gap, interviewees reflected a broader range of approaches.

It was common for CEs to describe their authority as a 'public health authority' but practical implications, including the extent to which this was systematically reflected in local authority decision-making processes differed across sites. As almost all council activities could be linked to public health outcomes, describing a local authority as a public health organisation could simply express a tautology, reflecting the status quo. In other cases, a public health ethos was reflected through organisational arrangements, in cross-directorate working through service delivery agreements and in its importance being expressed by all stakeholders in a site, including Elected Members. In either case, the separate and distinct contribution of public health teams and a consensus over where input was most needed could be difficult to identify.

## 9. Conclusions

Since the reforms were implemented in April 2013, there has been continued debate over their advantages and disadvantages, short-term impact and likely longer-term effects (Gadsby et al., 2017). As well as considering impact on specific preventive services (Anderson and Cheeseman, 2016; Fagan et al., 2017), the provider landscape and public health outcomes, there are wider debates over the extent to which local authorities are fulfilling their public health leadership role, the effect of the reforms on the role (Willmott et al., 2016) and sustainability of the public health profession and the influence of changes in decision-making contexts and governance arrangements on priority-setting for public health (Marks et al., 2015; Hunter et al., 2016).

Variation is a hallmark of local government and the extent of variation across our 10 case study sites is indicative of the different ways in which prevention and public health are being defined, the public health contribution interpreted and the reforms implemented across local authority areas. This is, in part, a function of different needs and priorities and how they are reflected in the mandates of democratically elected local authorities. It also reflects the varying commitments of local authorities to a public health agenda prior to the reforms and local differences in how the transition was managed and new organisational and accountability relationships established.

This study illustrated ways in which a social perspective could be integrated into traditional preventive services, a public health perspective could influence local authority services and political commitment to mainstreaming a public health agenda could be demonstrated across local authority directorates. It showed that while all these aspects could be demonstrated, they were implemented to varying extents across case study sites. This underlines the importance of disseminating good practice and examples of innovation.

The national surveys of DPH and CCG members of HWBs (n=39 (2015) and 36 (2016)), showed small shifts towards co-design and community participation; identification of underserved groups; with increased use of VCSE organisations, new providers and new venues. Areas where over 70% of respondents agreed over changes since the reforms included: adequacy of funding for the NCMP; the development of integrated health and wellbeing services; asset-based approaches; reconfiguration of services; use of the budget across local authority directorates; and funding for public health from other directorates. Innovation through cross-council working with partners was also highlighted.

In a previous NIHR-funded project on commissioning for health and wellbeing in the NHS, dimensions of governance relevant for public health were explored (Marks et al., 2011). These included: principles (e.g. stewardship, social justice, accountability); governance arrangements (e.g. roles and responsibilities, standards, targets); modes (hierarchies, markets and networks); and levels of governance. It was noted that emphasis on one aspect of governance can lead to neglect of others and equity and a population perspective are key principles underlying governance for public health. Moreover, the discipline of public health itself incorporates different elements, including healthcare public health and wider determinants of health, each with different implications for governance arrangements. The current study indicates changing relationships across professional, managerial and democratic accountability for public health and across national standards and local governance arrangements.

Unlike education and social care, public health lacks an external inspection/audit body in local authorities, with the emphasis placed on the democratic role of Elected Members and the monitoring function of Scrutiny Committees. However, this could raise challenges for public health. Some DsPH expressed concerns over the loss of a population perspective or an emphasis on doing 'what people in the community say they want', rather than proactively focusing on improving population health outcomes. VCSE sector interviewees emphasised their role in connecting with community networks, also implying that a proactive approach was required. In the same way, where Health Scrutiny committees relied on local electorates raising public health issues, the emphasis remained mainly on health care. Moreover, the requirement to produce an independent annual report was unusual in a local authority context and the usefulness and relevance of a DPH annual report was criticised in some sites.

From a governance perspective, a key question is the extent to which variation in relation to public health outcomes and health equity is acceptable. Improving population health involves a commitment to put health first, address social determinants of health and health inequity and to implement essential public health services at scale. These elements are reflected, for example, in the promotion of ten 'Essential public health operations' (WHO, 2012), indicators included under the four domains of the PHOF (DH, 2012) and Marmot's six policy priorities for reducing inequity in health (Marmot Review, 2010). As part of this, how is the appropriate level of public health staff to be defined, monitored and assured?

In summary, variation across authorities in how underlying issues concerned with prevention and health inequalities are defined, the public health role is understood and priorities are decided means that the reforms may result in a number of quite different futures for public health. A DPH summed it up as follows:

*One of the key questions is going to be, the extent to which the public health role ... is enforced and councils have to have a strong public health function, or the extent to which central government lets it wither on the vine so long as Public Health England is doing OK, and I think that's quite an interesting question, because authorities will vary and they will change depending on the political leadership at the time.*

While all can agree that prevention is better than cure, commitment to prevention in the face of immediate and urgent demands for health care in the NHS and social care in local authorities is difficult to achieve or sustain. In a local authority context, this is likely to depend on a strategy where a longer-term commitment to prevention, improving public health outcomes and reducing health inequalities is reflected across all directorates and Elected Member portfolios. In a local authority context, therefore, political leadership is key.



## 10. Dissemination plans

Project findings will be of interest to policy makers, academics, local authority and NHS commissioners, Elected Members, public health professionals, VCSE sector organisations and members of HWBs, including local Healthwatch. Our External Advisory Group met three times over the course of the project, as planned, and provided guidance on effective dissemination strategies. They emphasised the importance of disseminating results quickly in a fast moving policy field and of ensuring that investment in research has an impact. The importance of targeted dissemination material for specific groups was also emphasised. We are keen to make the final report available as soon as possible on our project website, given interest in study findings from senior policy and practice colleagues. (Previous research reports have already been made available.)

To date, the following dissemination activities have been undertaken:

### Presentations

- *Reframing health inequalities in England: improving and extending life in the context of local government perspectives and priorities.* Presented at the Applied Quantitative Methods Network (AQMeN) International Conference, Edinburgh (October 26-27, 2016) (SV)
- *Emerging findings:* Seminar for DH (Quarry House, Leeds with video link to Richmond House) (November 28, 2016) (LM and AM)
- *Local authority commissioning of NHS Health Checks: an exploratory evaluation.* Health Economics Study Group meeting (January 4-6, 2017) (AM and DL)
- *Local authority commissioning of the NHS Health Checks programme: a mixed methods evaluation* (Poster) Getting serious about prevention 2017. Improving Cardiovascular Health Together (Conference, February 9, 2017), Manchester (SV/AM/DL)
- *The hallmarks of successful public health leadership.* Policy session at LGA/ ADPH annual public health conference, 'Extending influence to promote health and wellbeing' (March 9 2017), London ( LJ, DH and SV)

### Articles published

Jehu, L.M, Visram, S., Marks, L., Hunter, D.J., Davis, H., Mason, A., Liu, D., Smithson, J. (2017) Directors of public health as 'a protected species': qualitative study of the changing role of public health professionals in England following the 2013 reforms. *Journal of Public Health*, <https://doi.org/10.1093/pubmed/fox154>

### Articles ready for submission

- Local authority commissioning of NHS Health Checks: a regression analysis of the first three years

### Articles in preparation

- Health inequalities: changing perspectives and practices in a local government context
- Local authority expenditure and childhood obesity
- The impact of the 2013 changes to public health in England on the role of the voluntary sector
- Impact of the public health reforms: overview of project findings
- Governance for public health in a new context
- Innovation in public health

**National conference: The impact of the public health reforms**

A national conference to disseminate project findings was held at York on 28th June, 2017 (see Appendix 7 for the conference programme), with around 50 participants in total including public health professionals, other local authority commissioners, Healthwatch, the Voluntary sector, NHS Trusts, and national organisations, including PHE and Health Education England. All those who participated in the research were also invited to attend. The programme included external speakers, an expert panel and three presentations from the project team. Three facilitated break out groups enabled broader discussion. There was a great deal of interest in project findings, as reflected in the conference evaluation (see summary in Appendix 7) with numerous requests for copies of the final report when available.

In addition to peer-reviewed articles and articles in the practitioner press, as described above, we intend to disseminate findings through networks of the Local Government Association and Public Health England. PPI lead for the project, Joanne Smithson (CI) will disseminate findings through local, regional and national Voluntary and Community Sector networks. Fuse (the UKCRC-funded Centre for Translational Research in Public Health) also provides opportunities for networking across the NHS, local authority and third sector partners across the North East and nationally.

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