

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

*Results of a national survey of Directors of Public Health and
Clinical Commissioning Group members of Health and Wellbeing
Boards*

Research Report 4

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Disclaimer

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Abbreviations

ADPH: Association of Directors of Public Health
BME: Black and Minority Ethnic
BOS: Bristol Online Survey
CAMHS: Child and Adolescent Mental Health Services
CCG: Clinical Commissioning Group
CSU: Commissioning Support Unit
DH: Department of Health
DsPH: Directors of Public Health
HSCIC: Health and Social Care Information Centre
HIA: Health Impact Assessment
HEA: Health Equity Assessment
HWB: Health and Wellbeing Board
JSNA: Joint Strategic Needs Assessment
LA: Local authority
LGA: Local Government Association
NCB: National Children’s Bureau
NHS 5YFV: NHS Five Year Forward View
NIHR: National Institute for Health Research
OSC: Overview and Scrutiny Committee
PCT: Primary Care Trust
PHE: Public Health England
PHOF: Public Health Outcomes Framework
PRP: Policy Research Programme
PRUComm: Policy Research Unit in Commissioning and the Healthcare System
RB: Ring-fenced budget
SPHR: School for Public Health Research
SPOT: Spend and Outcome Tool
SROI: Social Return on Investment
VCSE: Voluntary, Community and Social Enterprise
VONNE: Voluntary Organisations’ Network North East

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Executive Summary

Background

This report is the fourth in a series of research reports forming the scoping phase of a Department of Health Policy Research Programme-funded research project entitled '*Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision*'.

The research project as a whole is designed to evaluate the impact of the public health reforms with particular reference to the ring-fenced public health budget, commissioning public health services and the new public health role of local authorities. This report presents findings from a national survey of Directors of Public Health (DsPH) and Clinical Commissioning Group (CCG) members of Health and Wellbeing Boards (HWBs). The survey explores deployment of the ring-fenced public health budget, including pooling arrangements; commissioning and provision of preventive services, including innovative approaches; the public health leadership role of local authorities in promoting health and addressing health inequalities; public involvement, including involvement of both older and younger age groups in shaping services; support required by commissioners; and changes in the public health system, including collaborative arrangements. One section of the survey focuses on adult lifestyle services and initiatives to address childhood obesity. The intention is to repeat this survey in 12 months (over July and August 2016), to identify changes over time.

Methods

Bristol Online Survey (BOS) was used to create survey tools and each survey went through several iterations in consultation with the project team prior to piloting. Personalised survey invitations were sent out in early August 2015 to 152 CCG members of HWBs and all 135 DsPH (i.e. 287 individuals in total).

Respondents could provide comments for many of the questions and descriptive statistics for each question are supplemented by a summary of comments. For four questions, answers were free text only. As the number of respondents who provided comments varies by question, numbers and roles of respondents are also reported.

Results

There were 39 responses: 11 CCG members of HWBs (response rate: 7.2%); and 28 DsPH (response rate: 20.7%). The percentage of local authorities represented was 23.7% (36/152) and all nine regions of England were represented. Local authorities that responded to the survey were similar to non-respondents in terms of their population sizes, deprivation levels and per-capita spend on public health. However, the responding LAs had a higher proportion of people of white ethnicity, and a

higher proportion of people living in rural areas. Compared with non-responding LAs, authorities who responded to the survey were more likely to be unitary authorities or shire counties.

A majority of respondents considered that the public health budget protected public health services and should be retained in its present form, although there was less support for preserving the distinction between mandated and non-mandated public health services. Around half of respondents considered that the budget provided useful data for comparison across local authorities. Most respondents (87%) reported that the budget had been used for public health activities across local authority directorates while less than half (39%) reported that top-slicing of the public health budget had taken place in 2014-15.

While a majority considered funding to be adequate for mandatory functions, such as the National Child Measurement Programme, sexual health services and NHS Health Checks, around half of respondents considered that public health funding was inadequate for services to address alcohol misuse, obesity in children and adults, or for promoting exercise for children. In contrast, over two thirds considered stop smoking services to be adequately funded. Pooling of public health funds across CCGs and local authorities was uncommon across all services: services where pooling was most often reported were adult exercise schemes, drug and alcohol services and prevention of excess winter deaths, but even for these services less than one quarter of respondents reported pooling initiatives. However, there was more evidence of funding from more than one local authority directorate for these services, especially for the prevention of excess winter deaths, reported by a majority of respondents.

Changes in community involvement in commissioning preventive services were less than might have been anticipated. The majority of respondents identified little overall change in community participation in areas such as identifying local priorities, capacity-building, influencing the kinds of services commissioned or in the co-design of services. However, in related areas of developing closer links to communities, asset-based approaches, and new integrated health and wellbeing services or working with underserved groups through the Voluntary, Community and Social Enterprise Sector (VCSE), a majority agreed that such approaches had been encouraged by the reforms.

In relation to those involved in delivering preventive services, whether from the NHS, VCSE sector, local authority or private providers, between one half and two thirds of respondents considered levels of involvement to be the same. However, reductions in the use of health trainers and NHS Trusts were reported by around a third of respondents, while greater involvement of volunteers, VCSE organisations, local authority employees and pharmacists was reported by over one third (with 44 % identifying increases in the involvement of volunteers and local authority employees). VCSE organisations, health trainers and local authority employees were the groups most often described as involved in healthy eating and exercise

initiatives, whereas GPs, pharmacies and NHS Trusts were most often described as providing stop smoking services. VCSE organisations and NHS Trusts were prominent in providing substance misuse services.

Over three quarters of respondents considered that adult lifestyle services were being reconfigured and over half considered that services were being provided in a wider range of venues and that local authorities were commissioning new providers. The majority of respondents reported cross-directorate consideration of ways to encourage healthy lifestyles for adults and for children. However, only one third considered that additional services were being commissioned. In particular, a majority of respondents considered that the reforms had not led to more services being commissioned by local authorities in relation to healthy eating or weight management programmes to address childhood obesity.

A majority reported that their local authority had funded broader approaches to tackling childhood obesity, such as healthy schools initiatives and improved access to leisure programmes. However, using the planning system to regulate fast-food outlets around schools was less common, identified by one quarter of respondents.

In response to an open question on defining innovation in public health services, respondents highlighted asset-based approaches, cost-effectiveness, cross-directorate and multi-disciplinary working. A majority considered that councils had created a climate for developing innovative approaches through prioritising areas where innovation was needed, commissioning integrated services, testing new approaches to public health services and facilitating cross-council working with key partners. However, there was little evidence of financial incentives being used.

With the exception of statements that HWBs were leading on wider public health issues and that health impact assessment of local authority policies were being developed, two areas where just over half of respondents were neutral or disagreed, a majority of respondents held positive views of the ability of DsPH to exercise an independent voice and over the leadership role of local authorities in areas such as having clear public health objectives, developing multi-agency approaches to public health and integrating public health across directorates. However, a more critical response was evident in views of the public health system. While collaboration across CCGs and local authorities was considered good by most respondents (82%), there was less support for the statement that links between GP practices and local services had improved. A majority of respondents (90%) disagreed with the statement that data sharing across primary care and public health teams had become simpler. A slightly smaller majority disagreed with the statement that communication for health protection had become simpler, with only 13 % of respondents agreeing that this was the case. The NHS was less able to provide or commission preventive services according to over 80 % of respondents and 80% of respondents did not agree with the statement that more public health expertise was available to CCGs. In relation to whether additional support was needed by public health commissioners (from Public Health England, NHS regional teams and

commissioning support units) answers were fairly evenly balanced, but more than half did not consider additional support was needed from the latter.

In comments on enablers and barriers to improving health outcomes, budget restrictions figured prominently as a barrier. However, respondents also cited examples of a lack corporate ownership of a public health agenda, the domination of health and social care and the need for national leadership 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, was emphasised.

Key enablers for achieving better health outcomes included the quality of relationships between individuals, across the local authority and public health teams or across partners and wider stakeholders. 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. Respondents also highlighted the importance of front-line services making 'every contact count'; the role of local authorities in developing place-based approaches to public health; and community engagement as fundamental to promoting wellbeing.

HWBs were viewed as playing an important role but required further development and a stronger focus on public health outcomes. Surprisingly, the role of councillors as advocates and enablers was mentioned by only three respondents. It was noted that 'in less desperate times', the relocation of public health to local authorities was itself an enabler to improving health outcomes.

Conclusions

The response rate for this survey was very low, both for DsPH (28/135) and especially for CCG members of HWBs (11/152). This means that the representativeness of views expressed by respondents is unknown and there is a risk that our findings are biased – although we can neither prove nor disprove this. 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. Responding authorities were more likely to be unitary authorities or shire counties than non-responders.

In addition, it is difficult to assess the impact of the reforms in isolation from planned reductions in the public health budget and ongoing reductions in local authority budgets, which coincide with the reforms. Local authorities differed in levels of public health investment, partnership arrangements and involvement prior to the reforms and these factors, combined with transfers of public health funds which reflected the historical levels of public health spend in the former Primary Care Trusts, influence the extent of current activities, irrespective of the reforms.

The results of the national survey demonstrate a range of views in response to most questions. The public health leadership role of local authorities and their support for innovation were viewed positively by the majority of respondents, and the reforms were considered to have encouraged reconfiguration, new integrated wellbeing services and greater involvement of the VCSE sector and of volunteers. However, the impact of the reforms on aspects of the new public health system was mixed. While over 80% of respondents considered that collaboration across CCGs and local authorities was good, 90% of respondents did not consider that data sharing across primary care and public health teams had become simpler, while 80% of respondents did not agree with the statement that communication for health protection had become simpler. The survey showed that there was scope for further development of community involvement in priority-setting and in co-design of services, where there was little evidence of change since the reforms. While the public health budget was reported as being used across local authority directorates, there was less evidence of funding from more than one directorate for the range of public health services reflected in the public health budget reporting categories.

Reconfiguration of lifestyle services funded through the public health budget was taking place but impact was difficult to assess. As two-thirds of respondents in our survey reported greater cross-directorate working to encourage healthy lifestyles in children, project analyses of the effect of the reforms will need to recognise that improved outcomes may be due to initiatives commissioned outside of the public health grant.

In conclusion, while response rates do not allow for generalisation of results, the descriptive statistics, combined with summaries of the additional comments provided in response to many of the questions, provide an indication of the impact of the reforms across the three workstreams of the study at the time the survey was carried out (August 2015). Issues raised will be explored in more detail in the case study sites. Results will also provide a useful context for interpreting national data on the deployment of the ring-fenced public health budget and inform a planned project report on innovation.

1. Introduction

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 Department of Health (DH) Policy Research Programme (PRP). The project aims to evaluate the impact of public health reforms resulting from the Health and Social Care Act 2012. The research team is made up of members from the Universities of Durham, York and Coventry and from Voluntary Organisations' Network North East (VONNE). The project began in January 2015 and will conclude in June 2017.

The reforms marked a substantial reorganisation of the public health system in England, involving the transfer of public health responsibilities from the NHS to local authorities. As a result, NHS Directors of Public Health (DsPH) and their teams were relocated to local authorities. This transfer was also accompanied by a public health grant that was initially ring-fenced for two years, with the ring-fence subsequently extended until 2015-2016.

This study focuses on the impact of three new responsibilities that directly result from the reforms, reflected in three inter-related workstreams: (1) new budgetary responsibilities; (2) local authority responsibilities for commissioning preventive services through a range of providers; and (3) a leadership role for local authorities in promoting health and addressing health inequalities. Methods include surveys to provide a national overview, data analysis of spend and health outcomes and in-depth study of ten case study sites across England. Each workstream uses a mix of quantitative and qualitative methods and, where possible, explores the impact of the reforms on health outcomes.

Evaluating the impact of the reforms is made more complex by variation in local authorities in terms of local circumstances, and the range of partnership initiatives and innovative preventive services which predate the reforms. A previous National Institute for Health Research (NIHR)-funded study on commissioning for health and wellbeing in the former Primary Care Trusts (PCTs) (Marks et al., 2011), which included public involvement in commissioning, provides a basis for comparison as well as a governance framework for public health on which this research project can build.

2. National survey of Directors of Public Health and Clinical Commissioning Group members of Health and Wellbeing Boards

2.1 Background and rationale

This report presents the results of a national survey of DsPH and of Clinical Commissioning Group (CCG) members of Health and Wellbeing Boards (HWBs). In line with the iterative approach adopted throughout the scoping phase, the national survey builds on results of previous research reports. This is the fourth report of the scoping phase of the project (January to September 2015). Previous research reports completed as part of the scoping phase are:

- Report 1 (April 2015): Views of national stakeholders;
- Report 2 (May 2015): The public health budget;
- Report 3 (July 2015): Results from two national surveys:
 - (1) Local Healthwatch and Voluntary, Community and Social Enterprise (VCSE) members of HWBs and
 - (2) VCSE organisations involved in health promotion and prevention.

The purpose of the scoping phase is to help inform selection of ten case study sites and the development of research instruments for case study research. Selection of sites was also informed by other criteria including geographical spread, different political control, levels of disadvantage and the inclusion of multi-district councils. This report also makes an independent contribution to project aims and objectives across each of the three workstreams described in Section 1. The intention is to repeat this survey in 12 months (July and August 2016) to identify changes over time.

Topics explored through the survey include: deployment of the ring-fenced public health budget, including pooling arrangements; commissioning and provision of preventive services; the public health leadership role of local authorities; involvement of local communities, including involvement of both older and younger age groups in shaping services; support required by commissioners; and changes in the public health system, including levels of collaboration. Overarching themes include addressing health inequalities; innovation in the provider landscape; integrated approaches; and public involvement. One section of the survey focuses on adult lifestyle services and initiatives to address childhood obesity. These topics will be further explored through in depth study of ten case study sites.

2.1.1 Recent developments

Research report 1 (April 2015) included a summary of research and policy developments which have taken place since the reforms were implemented in 2013. More recently, responsibility for public health services for children (0-5) has been transferred from the NHS to local authorities (from October 2015); further research has been made available on health inequalities and the effects of social factors on children's health; there is a planned reduction in the ring-fenced public health budget; and further emphasis on the scope for public health action across local authority directorates in relation to obesity. These are briefly discussed in turn.

From October 2015 to March 2016, £430 million is to be allocated to local authorities as responsibility for commissioning public health services for children under five, including health visiting and the Family Nurse Partnership Programme, transfers to local authorities from NHS England. This is viewed as an opportunity to integrate services to improve the health and wellbeing of children and strengthen early intervention (Local Government Association, 2015a). However, it also creates public health challenges for local authorities. For example, a recent report from the National Children's Bureau (NCB) (NCB, 2015) demonstrates 'stark variations' in the health of young children (0-5) across the country according to where they live – including variation among the most deprived areas. The report suggests that 'despite their challenging circumstances, there is an opportunity for local authorities and their health partners to do more to improve young children's health and well-being'.

Also reflecting an emphasis on children's health is a series of reports on health and health inequalities. In order to build on the strategic review of health inequalities in England post-2010 (the Marmot review), DH commissioned a suite of reports from the UCL Institute of Health Equity 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, Public Health England (PHE) has published a series of 'Practice Resource' papers, also produced by the UCL Institute of Health Equity, 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. (Available at: <https://www.gov.uk/government/collections/local-action-on-health-inequalities-practice-resources>).

It has also been argued that the move for devolution of powers, spearheaded by Greater Manchester, provides opportunities to address linked social determinants of health through a 'place-based approach to public health leadership' (Local Government Association, 2015b). The NCB report mentioned above also advocates the devolution approach being developed across Greater Manchester, highlighting its 'strategic system-wide prevention and early intervention board' which emphasises early childhood development.

In addition to further research on health and health inequalities are recent campaigns for 'health on the high street' (Royal Society for Public Health, 2015), to include the role of local planning in influencing the availability of fast food outlets. Drawing on the Scientific Advisory Committee on Nutrition (SACN) report (SACN, 2015) on the relationship between dietary carbohydrates and health, PHE reinforced the importance of reducing intake of free sugars by at least half in all age groups - and highlighted the fact that intake is three times higher than recommended in 11-18 year olds (PHE, 2015). As the NCB report reiterates, obesity and tooth decay in children are at their highest levels in deprived areas, where fast food outlets, often targeted at children, are most heavily concentrated. While an earlier Local Government Association (LGA) report (LGA, 2015c) provided examples of how local authorities could address diet and obesity in their local areas, this report also

emphasises that whether such initiatives can be expanded depends on resources being made available.

In relation to the public health budget, the Treasury announced in June 2015, as part of wider government action on deficit reduction, that the 2015/16 public health grant to local authorities would be reduced by £200 million. This equates to 7% of the £2.8 billion 2015/16 ring-fenced public health budget. DH released a consultation on these 'in-year savings', with the principal question of how each local authority's contribution to the saving would be calculated, with DH favouring a 6.2% reduction in all local authority public health budgets. Following this consultation it was decided (Public Health Policy and Strategy Unit, DH, 2015) to reduce each local authority's grant by an equal percentage with effect from the fourth quarterly instalment (brought forward from January 2016 to November 2015). This reduction in the ring-fenced grant is in the context of a 1.7% average reduction in the level of grant provided to councils for 2015/16. There will also be changes in local authority public health budgets as allocation moves further towards distribution based on population needs.

Comments included as part of the survey reflected these concerns over budget cuts, children's health and health inequalities.

2.1.2 Related surveys

Policy interest in the public health reforms has led to a number of recent surveys, albeit with different aims and objectives to the national survey described in this report. These surveys include the following:

- A national survey (late 2014) (unpublished) of core HWB members carried out as part of a School for Public Health Research (SPHR)-funded project on prioritising public health investment;
- A national survey carried out as part of a DH PRP study evaluating the leadership role of HWBs (July-September 2015). This was distributed to HWB Chairs and DsPH;
- The PHOENIX study (April 2013 to December 2015) examines the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health. Two national surveys (July 2014 and September 2015) of DsPH and Councillors who lead on public health issues were carried out. The surveys cover aspects related to the use of the ring-fenced budget and the public health role. The PHOENIX study is part of PRUComm, which provides evidence to inform DH policy on commissioning;
- An annual survey (conducted by Ipsos MORI) of CCGs and local authorities to understand whether these organisations are getting the advice they require from PHE;
- The Association of Directors of Public Health (ADPH) English public health system 2015 survey: the survey was distributed to DsPH in February 2015 (prior to the announcement of the £200 million in-year cuts). A summary

document is available at: <http://www.adph.org.uk/wp-content/uploads/2015/06/ADPH-survey-summary-report-2015.pdf>

- A LGA Public Health Opinion Survey (LGA, 2015c) was sent to lead members for public health in 149 upper and single tier councils in England. This provides information from elected members on areas of concern and on the extent to which public health is embedded in local councils.

2.2 Methods

Groups to be targeted through the survey went through several iterations as a result of reviews of the research proposal, namely: (a) a survey of all members of HWBs; (b) separate surveys of DsPH and local Healthwatch members of HWBs; and (c) a survey of DsPH, local authority commissioners across directorates and CCG members of HWBs. This survey is a modification of (c), directed at DsPH and CCG members of HWBs. (Research report 3 includes results of a national survey of local Healthwatch members of HWBs). This represents a change from the research proposal, which identified local authority commissioners across directorates as one of the target respondent groups. However, their inclusion in a national survey was not specifically requested by reviewers and as the survey design developed, it became apparent that framing survey questions suitable for such a wide range of respondents was not feasible. Local authority commissioners form a diverse group and organisational structures and related executive posts vary by local authority, with an increasing tendency to organise a range of former directorates under new overarching arrangements (for example, 'People', 'Places', 'Transformation'). It was, therefore, decided to omit the broad range of local authority commissioners from the survey but to interview additional local authority commissioners during case study research, where this was relevant for exploring public health approaches across directorates. We also considered that questions related to public health would often be referred back to DsPH by other directors and that requesting initial recipients of the survey to forward it to others in the local authority was likely to prove ineffective.

The project team collaborated on survey design during June and July 2015. Findings from the three previous research reports in the scoping phase were taken into consideration when formulating the questions and the Bristol Online Survey (BOS) programme was used to produce the survey tool.

In developing the national survey, there was a tension between accessing the level of data required to address research questions and the practical limitations inherent in devising a 20 minute survey. As a result, some questions were made optional in order to maintain a relatively short and user-friendly research tool.

Three individuals were formally invited to pilot the survey: one DPH and two CCG members of HWBs. The pilot survey was completed by the DPH but it was not possible to pilot the survey in the time available with a CCG member of a HWB, despite two individuals being invited. This was due to their work commitments. However, there had been a representative from a CCG in the interviews with national stakeholders (Research report one) and specific issues of relevance to CCGs

raised by this interviewee were reflected in the survey. Moreover, CCG members were invited in their capacity as members of HWBs and survey questions were considered relevant for all HWB members. The DPH who piloted the survey confirmed that the questions were clear and relevant and that the estimated completion time was accurate and acceptable. Minor adjustments to the survey format and wording of questions were made in light of the reviewer's comments and further changes were made to clarify potential ambiguities. Permission was granted for this response to be included in the final analysis.

Previous research has demonstrated variable survey response rates from the target respondent groups. Consequently, in an attempt to maximise the survey response rate, an existing database of DsPH was updated and a new database of the most senior CCG members of HWBs was created (one CCG contact per HWB was targeted). Personalised survey invitations containing a unique URL survey link were sent via email on 5th August to the target individual's email addresses with the exception of 11 CCG members for whom only a generic email could be identified.

In some cases, DsPH covered more than one local authority area and so only one survey invitation was required, resulting in a total number of 287 email invitations being despatched (this number included the DPH pilot reviewer): 135 to DsPH and 152 to CCG members of HWBs. In light of this, an initial question was incorporated into the survey asking those who were a member of more than one HWB to answer the remaining survey questions in relation to only one local authority area, which they were asked to identify. Respondents who identified themselves as members of only one HWB were not required to reveal their local authority area as this information was already held in the database. Personalised reminder emails were sent to non-respondents on 17th and 21st August, prior to the closing date of 25th August (the survey was open for 21 days).

Descriptive statistics for each question are presented in the order they were asked in the survey. Respondents had the opportunity to provide comments for many of the questions (Q 5, 8-12, 14, 16, 17, 19-21, 24) and for four questions (Q 18, 22, 23, 25), answers were free text only. The descriptive statistics for each question are supplemented by a summary of comments provided by respondents. As the number of respondents who provided comments varies by question, these summaries are illustrative only, providing further information and specific examples in relation to survey questions. Numbers of DsPH and CCG respondents providing comments are reported separately, in preference to overall percentages.

2.3 Results

There were 39 responses including 11 CCG members of HWBs (response rate: 7.2%, 11/152) and 28 DsPH (20.7%, 28/135¹). The percentage of local authorities represented was 23.7% (36/152) and all nine regions of England were represented.

In light of these low response rates, particularly for CCG members, we could not report findings separately for the two groups of respondents. Rather than excluding data provided by CCG members, we therefore pooled the two sets of responses and highlighted in the text where patterns of response between the groups appeared to differ. For example, in several questions the 'don't know' responses came entirely, or almost entirely, from CCG respondents which indicates that this group of respondents appeared to be less well informed than DsPH respondents. However, as there was no response from 116 LAs, all findings from this survey should be generalised with extreme caution.

In this section, the graphs (Figures) provide detailed descriptions of responses to each question and sub-question. In the text, rather than reproducing information from the graphs, we consider some of the key findings and discuss subgroup differences of potential interest to readers. Where numerical descriptive statistics are reported, e.g. the percentage of respondents agreeing with the question, these are always based on the full number of individuals responding to the question.

2.3.1 Respondents and their roles

All the respondents were members of a HWB: 33 of the respondents were core members (84.6%) and others also held roles as co-chairs or vice chairs. Most respondents were members of only one HWB. The 39 respondents were from 36 local authorities, i.e. we had both CCG and DsPH responses from three organisations. Each region was represented. Local authorities that responded to the survey were similar to non-respondents in terms of their population sizes, deprivation levels and per-capita spend on public health. However, the responding LAs had a higher proportion of people of white ethnicity, and a higher proportion of people living in rural areas. Compared with non-responding LAs, authorities who responded to the survey were more likely to be unitary authorities or shire counties.

2.3.2 Funding public health services

The second set of questions (Q4-7) sought views over the ring-fenced public health budget, deployment of the budget in 2014-2015, and funding for specific public health services for 18 local authority public health budget reporting categories.

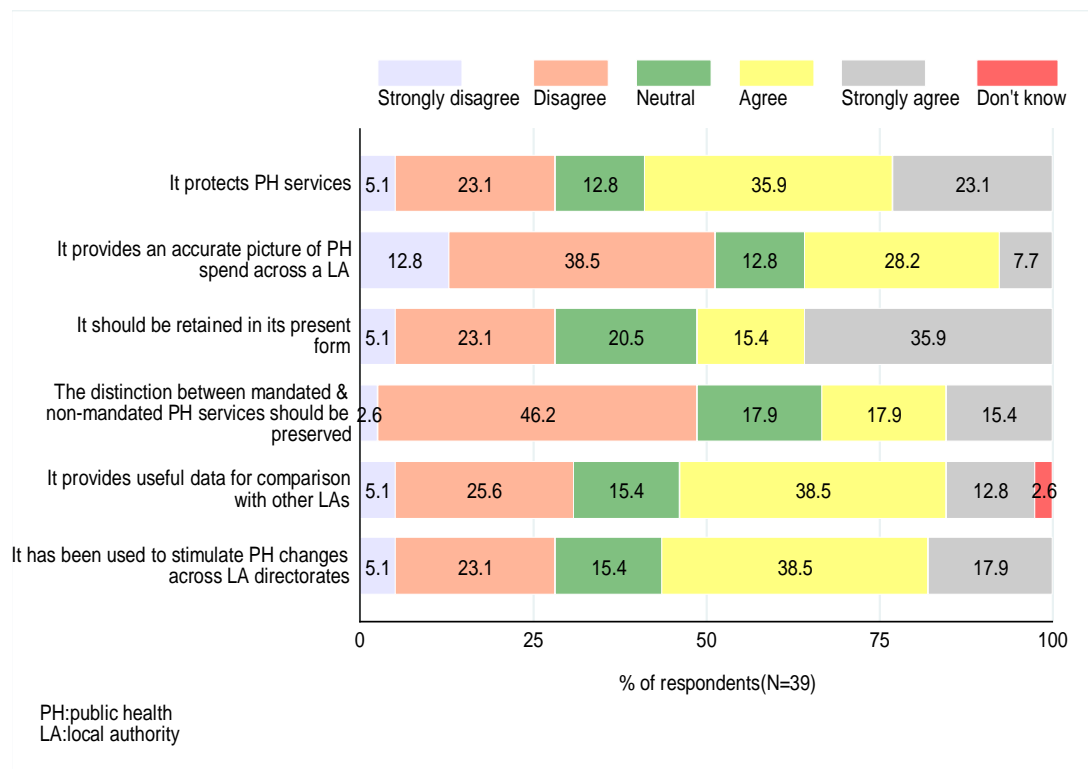
Views of the ring-fenced budget

Respondents were asked their views on six statements related to the ring-fenced public health budget. In general, CCG and DPH responses to this question were consistent.

¹ Some DsPH cover multiple LAs so there were 135 DsPH at the time of the survey.

Most respondents agreed that the ring-fenced budget protected public health services (59%), helped stimulate changes across local authority directorates (56%) and should be retained in its present form (51%). There was less support for maintaining the distinction between mandated and non-mandated services (33% in favour). The statement with the highest level of disagreement was that the budget accurately reflected public health spend (51%). However, one-third (36%) of respondents thought the budget accurately depicted public health spend across a local authority, and just over half of the respondents (51%) thought it provided useful data for comparing organisations. Full results are shown Figure 1.

Figure 1: Q4: What are your views of the following statements related to the ring-fenced public health budget?



Comments

In relation to the statement that the budget *protects public health services*, of the 17 respondents who provided comments (13 DsPH and four CCG respondents), eight agreed that the budget afforded some protection for public health services and that it provided a source of influence for DsPH, especially during a period of transition. However, the lack of ‘policing’ by the PHE, other pressures on local authority services and the lack of a ‘true ring-fence’ served to limit its impact. Nine of those who commented (including three of the four CCG respondents) were sceptical, with one DPH respondent describing the ring-fence as ‘meaningless’, given that existing budgets for social care were being ‘rebadged’ as health and wellbeing. The ring-fence was not applied and services were being cut. A further DPH commented:

The fundamental case for putting PH into local government is to address wider determinants - these are all being decimated by other cuts in local government funding.

Of the 13 respondents (nine DsPH and four CCG respondents) who commented on whether *the public health budget provided an accurate picture of public health spend across a local authority*, none considered it did so. Reasons included that: (a) it formed only part of funding to support public health given that local authority initiatives in other areas also supported public health; (b) it simply reflected traditional NHS public health spend; (c) it was only tangentially linked to public health outcomes; and (d) CCGs also funded some public health initiatives (from a CCG respondent). 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 PH outcomes are tenuous in some cases'.

Nevertheless, there were different views expressed over whether *the public health budget should be retained in its present form* (five DsPH and two CCG respondents). One DPH argued that it would give 'time to embed public health fully in the consciousness and fabric of councils. At that point it will make sense to take the ring-fence off, or at least be harder to argue for its continuation'. Others argued that in its present form it was not effective and if it was kept, it needed to be strengthened. One DPH considered that removing the ring-fence could be risky in some authorities. Points mentioned by CCG respondents included the need for more transparency over expenditure and a more central role for the public health budget in the context of combined health and social care budgets.

Thirteen respondents commented on whether *the distinction between mandated and non-mandated public health services should be preserved* (10 DsPH and three CCG respondents). Two DsPH agreed with keeping the distinction, as it ensured a level of consistency and helped to secure the grant. Two CCG respondents expressed the same view, as it clarified which areas were being addressed. However, the remainder 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. Two DsPH considered it inconsistent to make NHS Health Checks a mandated service but not smoking cessation or drug and alcohol treatment, as 'the evidence base on the latter is more convincing than on the former'. One DPH 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 PH interventions available.

There was also concern that mandated services would become the only focus for public health spending. Moreover, some mandated services (such as NHS Health

Checks and the National Child Measurement Programme) were described as about 'measurement rather than action'. One DPH 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?

Of the six respondents (five DsPH and one CCG respondent) who commented on whether the *public health budget provided useful data for comparison with other local authorities*, none was in agreement, given the extent of local variation in needs and priorities, providing a different view from the majority of respondents. The Spend and Outcome Tool (SPOT) was described by one respondent as not accurate enough to be useful for comparative purposes.

Finally, in relation to *using the public health budget to stimulate public health changes across local authority directorates*, there were five responses (DsPH only) including a very positive response from one DPH:

Yes. We have used the allocation to support developing the LA's role in improving Public Health. This has been done by replacing core funding with PH funding and beginning to change the way that services are delivered.

However, other DsPH reflected a situation where the budget had been used to balance the books or where changes were due to other factors, such as staff input, rather than the budget. A DPH commented 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).

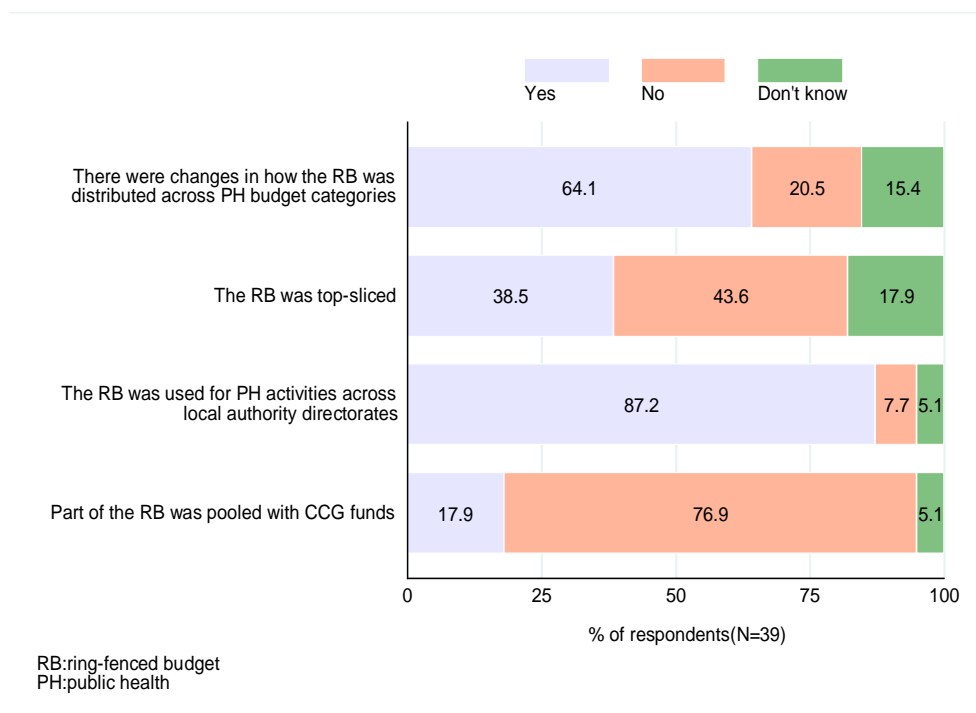
Deployment of the public health budget

A subsequent question (Q5) asked how the public health budget had been deployed in relation to four areas: changes across the public health budget categories; top-slicing of the budget; use of the ring-fenced budget across local authority directorates; and examples of pooling with CCG budgets.

Figure 2 shows the distribution of responses to Q5 across all 39 respondents. When asked about how the ring-fenced budget was deployed, most (64%) of respondents reported there had been changes across budget categories and that budgets had been deployed across directorates (87%). Less common amongst our respondents were top-slicing of the budget (38%) and pooled funds with CCGs (18%).

However, responses to Q5 from CCG respondents differed from DsPH responses: in particular, all the 'don't know' responses came from CCG respondents (data not shown). Amongst the subgroup of 28 DsPH, 75% reported that there had been changes in 2014/15 in how the budget was distributed across budget categories and 96% said the budget had been used across local authority directorates (data not shown). According to these DsPH, top-slicing (46%) and pooled funding with CCGs (21%) were less prevalent activities (data not shown).

Figure 2: Q5: Thinking about the 2014-15 ring-fenced public health budget, did any of the following apply in your local authority?



Comments

Ten out of the 11 respondents (10 DsPH and one CCG respondent) who made comments on *changes in how the ring-fenced budget had been distributed across public health budget categories* highlighted changes. These included changes as a result of the Joint Strategic Needs Assessment (JSNA); support of public health across other directorates (with reduction or decommissioning of original public health programmes); a new public mental health programme being created; a greater focus on statutory functions; money being transferred to leisure and children's services, third sector, and workplace settings; less funding for substance abuse and more for children's services and for sexual health services. One respondent reported that a Board had been established to prioritise funding.

Seven out of nine respondents (all DsPH) who commented on whether *the public health budget had been top-sliced* described how top-slicing had taken place. 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

commented that almost a third of the public health budget had been diverted to ‘in-house occupational health service, adult social care reablement services, adult social care placements and a whole host of corporate recharges’. Two respondents did not identify any top-slicing of the budget.

When asked if public health funds had been used *for public health activities across local authority directorates*, respondents (ten DsPH and one CCG respondent) listed a wide range of services including: road safety; park rangers; worklessness; homelessness; safeguarding; reablement services; carers' support; teenage pregnancy; children's centres; sports and leisure; adult education; domestic abuse; green spaces; safer journeys; and voluntary sector grants. One DPH commented:

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

Another DPH considered that ‘the overall effect of this was to reduce the amount of money being spent on public health services’ while the CCG respondent noted that ‘it was used for areas not traditionally covered by the public health budget’.

Seven respondents (DsPH only) commented on *pooling of funds with CCGs*, mentioning the following areas: children aged 0-3 (with VCS involvement); as part of Section 75 agreements; children's services; weight management; as part of the Better Care Fund; for prescribing of nicotine replacement therapy; and for ‘other small health promotion initiatives’. Pooling had been refused in one case as it was considered that the CCG wanted to use it for commissioning ‘core illness services’.

Funding for specific public health services

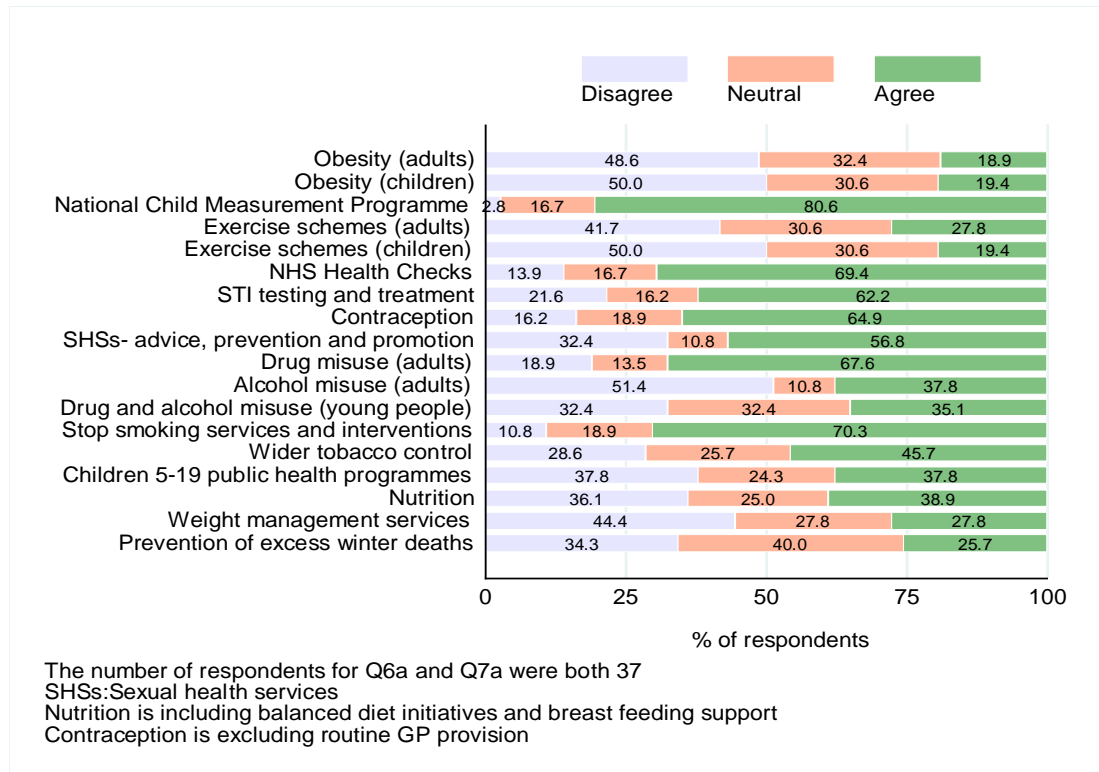
Questions 6 and 7 asked for views over the funding of specific public health services, reflecting the public health budget reporting categories. These questions were optional, so the number of individuals responding to each sub-question varied.

There were three parts to each question: (a) the adequacy of the budget for different purposes; (b) whether funds were pooled across the CCG/LA; (c) whether there was funding from more than one local authority directorate. Comments were not invited on these questions.

In terms of the adequacy of the public health budget (Figure 3), only around one in five respondents believed that funding was sufficient for tackling obesity in adults and children, or for providing exercise schemes for children. Areas where funding was least likely to be considered adequate were alcohol misuse (51% disagreed); obesity in children (50%); exercise for children (50%); and obesity in adults (49%). This contrasted with the mandatory functions of the National Child Measurement programme and NHS Health Checks where only 3% and 14% respectively considered funding to be inadequate. In addition, over 70% of respondents considered funding for stop smoking services was adequate. CCG respondents across Q6a and Q7a were

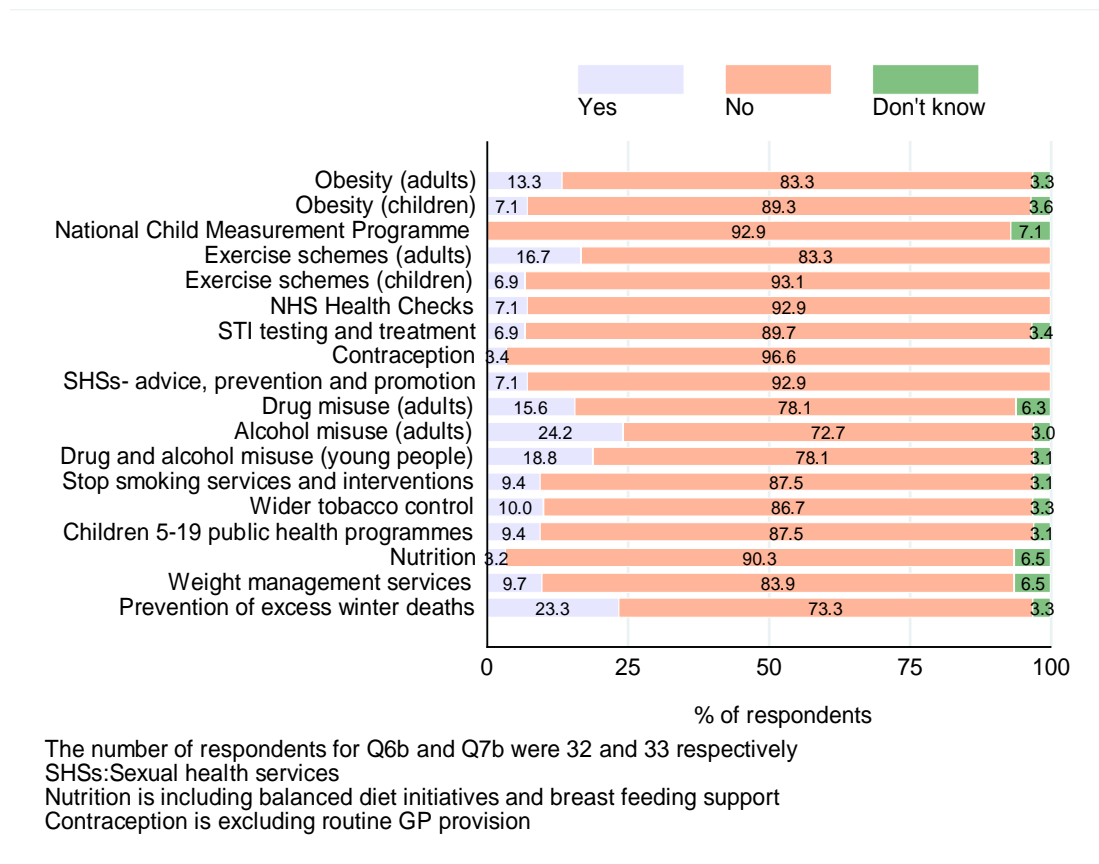
more likely to be neutral in their views than DsPH (40% vs. 17%) and were less likely to agree that funds were adequate (29% vs. 53%).

Figure 3: Q6a, Q7a: Funding of public health services in 2014-15: the ring-fenced budget was adequate



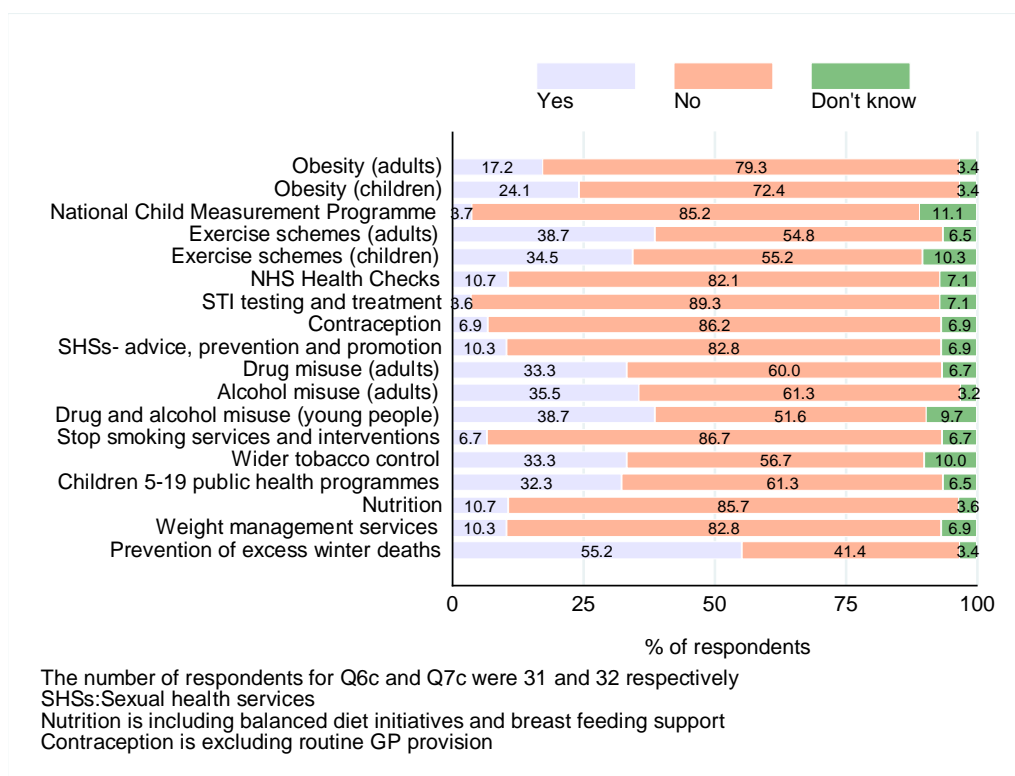
Pooling of funds with CCGs/ LAs was uncommon (Figure 4), but the areas where this most often occurred were adult exercise schemes, substance misuse and prevention of excess winter deaths. With one exception, all the 'don't know' responses for this question were from CCG respondents.

Figure 4: Q6b, Q7b: Funding of public health services in 2014-15: funds were pooled across CCG/LA.



According to our respondents, funding from multiple local authority directorates (Figure 5) was more common than pooled funding. However, the prevention of excess winter deaths was the only public health service cited by over half the respondents (55%). Around a third of respondents reported funding from more than one local authority directorate for exercise schemes (for adults and children), wider tobacco control, substance misuse, and for the children’s 5-19 programme.

Figure 5: Q6c, Q7c: Funding of public health services in 2014-15: there was funding from more than one local authority directorate



2.3.3 Commissioning and providing preventive services

The third section of the survey (Q8-10) explored issues which had been highlighted as potential benefits from changes in commissioning and providing preventive services resulting from the reforms, including new providers, approaches to promoting health more closely integrated with local communities and other local authority services and the use of financial incentives. These are discussed in turn.

Changes in providers of preventive services

Respondents were asked their opinions on the involvement of the provider groups listed in Figure 6 in delivering preventive services since the public health reforms.

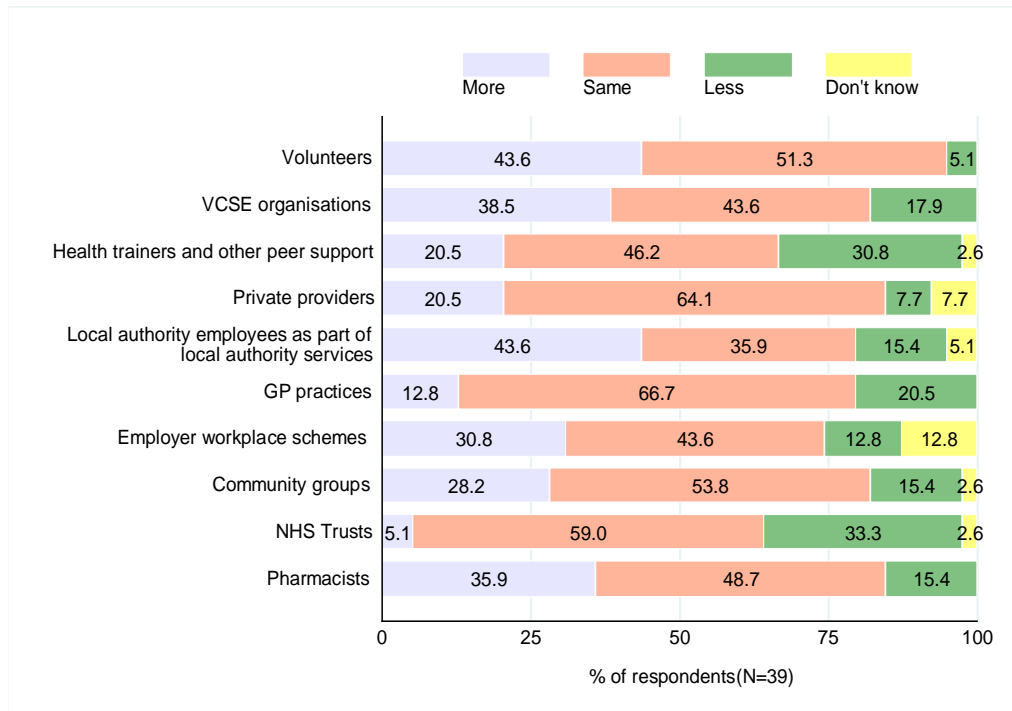
Over one-third of respondents indicated there was increased involvement of local authority employees (44%), volunteers (44%), VCSE organisations (39%) and pharmacists (36%).

For other respondents, involvement of the following was considered 'about the same' in delivering preventive services: volunteers (51%); VCSE organisations (44%); health trainers and other peer support (46%); private providers (64%); GP practices (67%); employer workplace schemes (44%); community groups (54%); and pharmacists (49%). Despite encouragement of a range of providers, 64% of respondents identified no change in private providers since the reforms but 30% of respondents reported less use of health trainers and other peer support.

Responses from CCG respondents and DsPH were different: specifically, all the 'don't know' answers for four factors were from CCG respondents. Moreover, there were

differing views on the involvement of local authority employees: 18% of CCG respondents vs. 54% of DPH subgroups answered 'more' for this factor.

Figure 6: Q8: Since the public health reforms are the following more or less involved in delivering preventive services in your local area?



Comments

These factors were commented on by few respondents (between two and seven). Four respondents (all DsPH) commented on the increased use of *volunteers*, who were described as involved in breast feeding support, weight management, peer support (as part of a new substance misuse service) and as part of integrated wellbeing services.

Six respondents (five DsPH and one CCG member) commented on the involvement of *VCSE organisations* with examples of greater involvement in areas including domestic abuse support services; substance misuse services; public mental health; community engagement; through Age UK; care closer to home; and social prescribing.

As for *private providers* (four comments, all from DsPH), Virgin Care was mentioned (for sexual health and for integrated children’s services) and an unspecified provider for Chlamydia diagnostics with involvement described as ‘about the same’ or ‘more’.

Use of *health trainers and other peer support* showed a different pattern: of the seven respondents who commented (six DsPH and one CCG respondent), three described a decline in services, due to budget cuts or new styles of procurement

while for the remainder, services had remained about the same and in one case had increased.

Only two comments (one DPH and one CCG respondent) were received for *community involvement* (with an example of local area partnerships) and for *involvement of GPs*, where preventive services were described as ‘about to decrease’ and a DPH commented that ‘general practice was often reluctant to ‘provide public health commissioned services’. Comments from three DsPH reflected greater involvement of local authority employees and included an example of an ‘Integrated Wellness’ contract which was awarded to a Council-provided arm’s length leisure company and ‘collaborative arrangements’. Two DsPH commented on *employer workplace schemes*, including a ‘Better health at work’ award and workplace wellbeing schemes.

Two DsPH commented on the greater involvement of pharmacists in prevention, with one DPH reporting that pharmacists were more engaged in delivering staff flu vaccinations, flu vaccination for care homes and public health awareness campaigns. A further DPH commented:

A dedicated pharmacist is co-located with the PH team and employed via a partnership agreement with the local pharmaceutical committee.

Respondents were asked whether any groups had been omitted from the survey. Two respondents (one CCG respondent and one DPH) added faith groups, churches and mosques, with an example of faith groups being involved in encouraging HIV testing, health walks and in promoting mental health. A third respondent highlighted the provision of food banks.

Community-based approaches

Potential benefits of the reforms included the capacity for local authorities to develop closer links with communities and with community networks, encourage asset-based approaches and promote greater involvement of the VCS with underserved groups. Respondents were asked their views on whether public health reforms encouraged any of the eight approaches (presented in Figure 7) in their local area. The majority of respondents (67%) indicated that the public health reforms had not encouraged the use of financial incentives for providers. Most respondents (between 59% and 72%) agreed that the public health reforms had encouraged the other approaches with the exception of addressing the ‘clustering of unhealthy behaviours’, where responses were more evenly balanced. In general, responses from CCG respondents and DsPH were consistent, except that all the ‘don’t know’ answers for four of the approaches listed were from CCG respondents.

Conditional upon their response to Q9a, respondents were then asked whether the same list of services had increased uptake in underserved groups (shown in Figure 8). Many of those who answered this question (Q9b) were uncertain of the impact of these approaches on underserved populations.

Figure 7: Q9a: Have the public health reforms encouraged any of the following approaches in your local area?

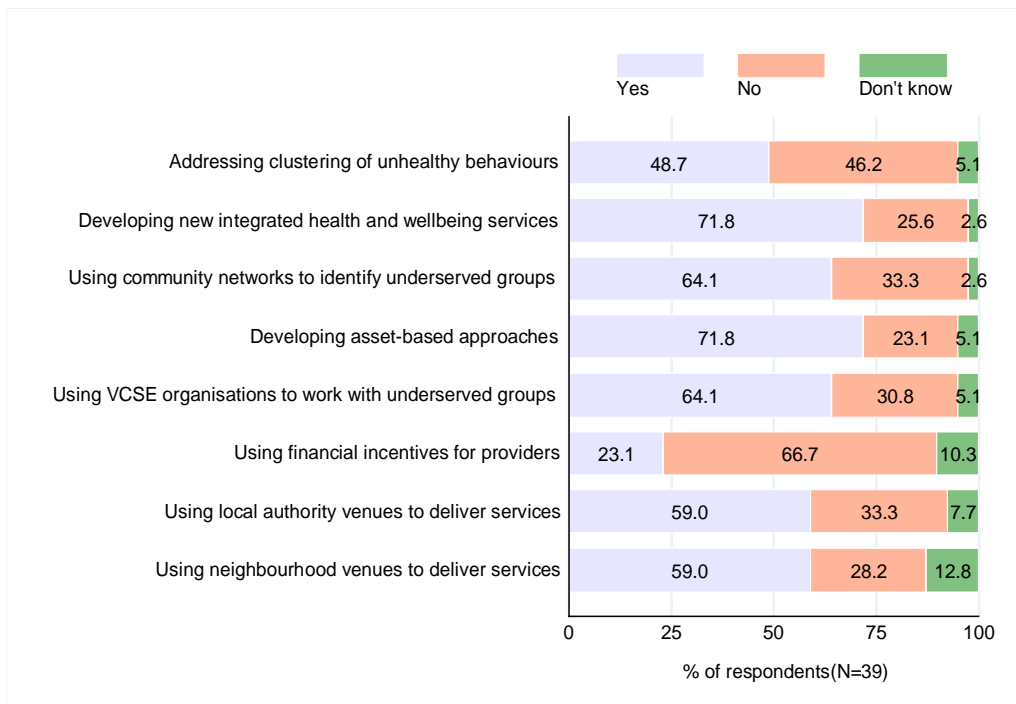
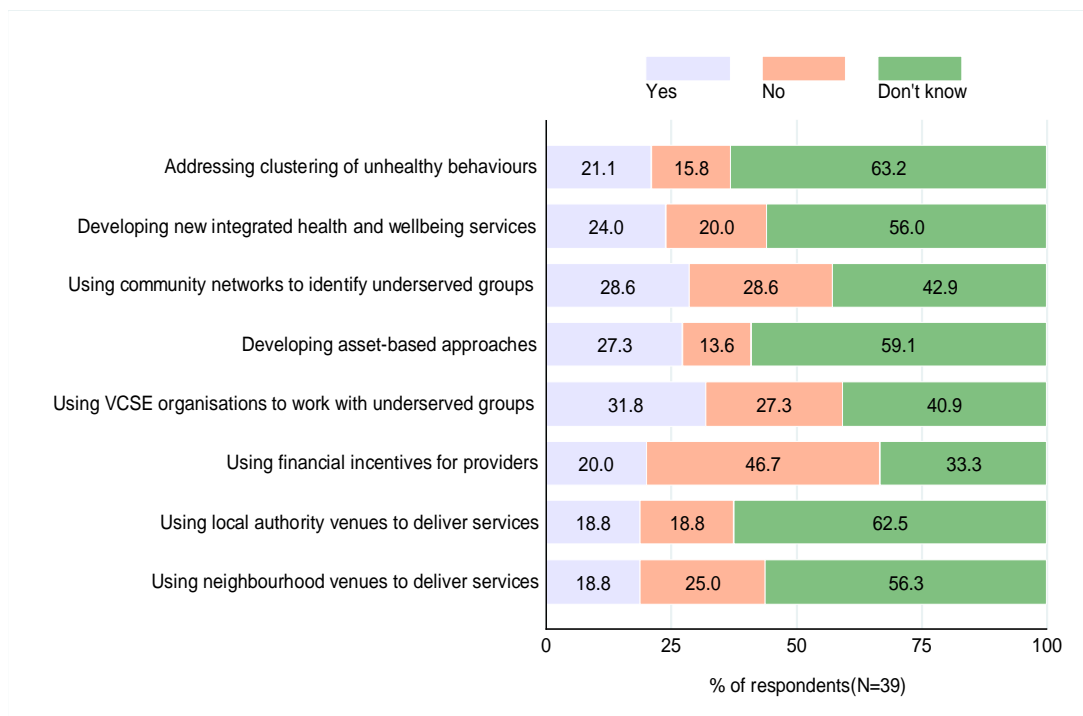


Figure 8: Q9b: If the public health reforms encouraged any of the following approaches in your local area, has service uptake increased in underserved groups?



Comments

Nine out of the ten respondents (nine DsPH and one CCG respondent) who provided comments considered the reforms had encouraged approaches which addressed the *clustering of unhealthy behaviours* (the remaining (DPH) respondent considered this predated the reforms). Examples included holistic approaches designed to avoid a 'silo' approach to lifestyle change, such as a new 'lifestyle hub' (jointly funded with the CCG), wellbeing initiatives, social prescribing and monitoring uptake through the NHS Health Check programme. Other initiatives included 'Making Every Adult Matter' and the 'Transforming Lives' approach. Only three respondents thought initiatives had increased uptake among underserved groups, with the remainder considering it too soon to tell.

In the same way, all but one of 16 respondents (13 DsPH and three CCG respondents) agreed the reforms were promoting *new integrated health and wellbeing services*, although ten DsPH thought it was too early to tell whether uptake had increased. One DPH noted that wellbeing services had been specifically commissioned to address needs of the most disadvantaged groups and another that there had been increased uptake by disadvantaged groups in relation to drug and alcohol services. Issues identified as key for developing integrated services included access to data and data sharing and integration of client databases to facilitate cross referrals across lifestyle programmes. Of the three CCG respondents who commented, one considered these initiatives had been driven from outside public health, another highlighted initiatives for frail elderly people and a third noted that deprived areas had provided the starting point for developing these services.

Comments or examples were received in relation to *community networks* (seven DsPH and one CCG respondent), *asset-based approaches* (four DsPH and one CCG respondent) and *using VCSE organisations* (six DsPH and one CCG respondent). All (except one) of those who provided comments saw the reforms as encouraging all three aspects and for the exception (asset-based approaches), such work was described as already ongoing and therefore not due to the reforms. Examples included:

- use of asset mapping involving members of the community in undertaking surveys;
- tackling obesity through using local assets;
- using community networks in needs assessment leading to improved intelligence;
- street triage;
- 'alcohol and drugs tent';
- using community networks to identify social isolation;
- social prescribing and mental health initiatives;
- Involvement of VCSE organisations in 'men in sheds' initiatives;
- Involvement of VCSE organisations in 'community genetics' projects in black and minority ethnic (BME) populations.

In relation to VCSE sector involvement, one DPH described the use of VCSE organisations as ‘an increased necessity in the wake of budget savings’ but considered that sustainability was unclear. For most of those who commented, the impact on inequalities was described as not known or it was considered too early to tell. Exceptions were projects on community genetics in BME populations and better intelligence about health needs of local communities.

Comments on using local authority venues (four DsPH and one CCG respondent) and neighbourhood venues (two DsPH and one CCG respondent) provided few examples, with the exception of a CCG respondent who described the provision of flu jabs in libraries. Two DsPH described the use of local authority venues as already established and another described how ‘the whole public sector estate’ was being explored to improve access’. One CCG respondent described how adult learning colleges were being used to deliver recovery programmes for mental health.

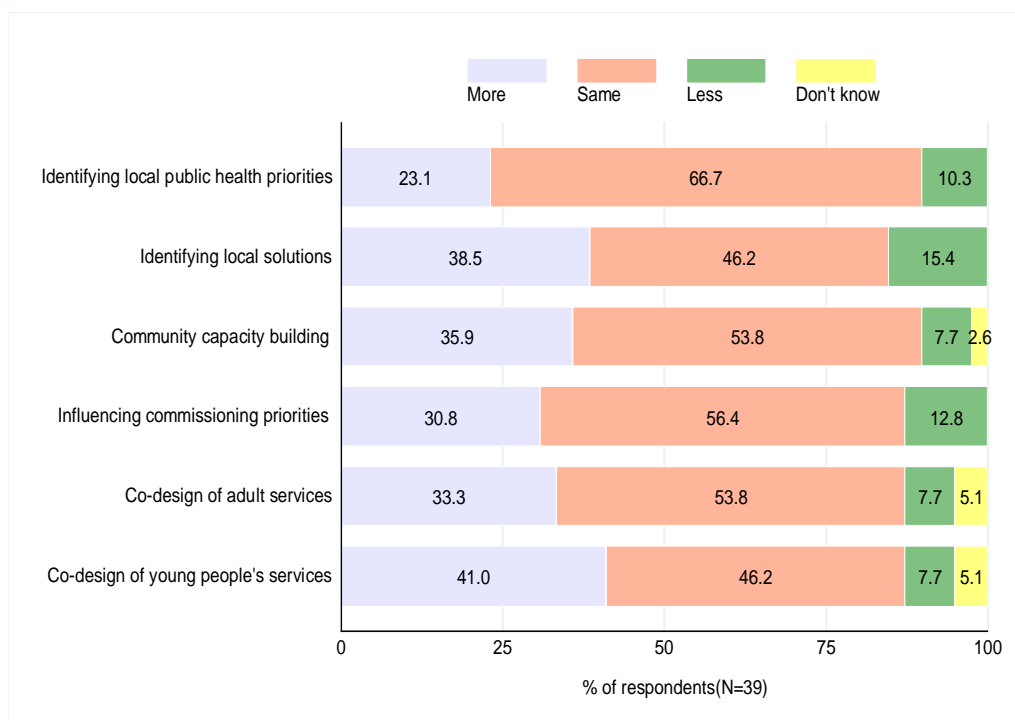
There were a few comments (three DsPH) on financial incentives, with only one example offered - of an eight per cent reduction in smoking in pregnancy achieved through provider incentives. One DPH noted that using financial incentives for providers predated the reforms and another that the same response applied to all the factors, namely that all these issues were already being addressed, with no changes deriving from the reforms.

Participation by communities

Increasing participation by local communities through, for example, identifying local priorities (and local solutions), community capacity-building, influencing the kinds of services commissioned or co-design of services, was considered a key potential benefit of the reforms. Respondents were asked their opinions over the extent to which public health reforms had affected participation by communities for activities listed in Figure 9. The majority of responses reflected the view that participation in all these activities by communities in local areas was the same as before the reforms. The percentage of ‘more’ and ‘same’ answers for co-design of young people’s services was similar. However, relatively few respondents thought that the reforms had led to greater community participation in identifying local priorities or in influencing service commissioning.

The responses from CCG respondents and DsPH differed. All the ‘don’t know’ answers were from the DPH subgroup. While 55% of CCG respondents thought communities participated more in the co-design of adult services, only 25% of DsPH held the same opinion.

Figure 9: Q10: To what extent have the public health reforms affected participation by communities in your local area in the following activities?



Comments

There were few comments on these factors (between three and six, with the majority from DsPH).

Issues raised included the following:

- small grants for identifying public health priorities;
- integrated wellbeing services for community capacity-building;
- local solutions identified through local area partnerships;
- extensive use of the VCS in influencing local commissioning priorities.

One DPH made the same comment for each activity, namely that the local authority continued to try and engage but this was difficult, and that single issues (such as budget cuts) were more successful in engaging local populations; another commented that public health teams lacked the capacity to engage. One DPH considered that all these issues were already being addressed, with no changes deriving from the reforms.

Initiatives in the co-design of sexual health services, substance misuse and domestic abuse services were mentioned. For young people's services (with comments from five DsPH and one CCG respondent), there was one example of co-design for services to address obesity but over half the comments concerned initiatives related to the emotional wellbeing of children, with examples including a 'very successful' re-procurement of Child and Adolescent Mental Health Services (CAMHS) to reflect a new emotional wellbeing approach, a new 'emotional wellbeing service co-

commissioned with schools’, and addressing children and young people’s emotional health through the JSNA.

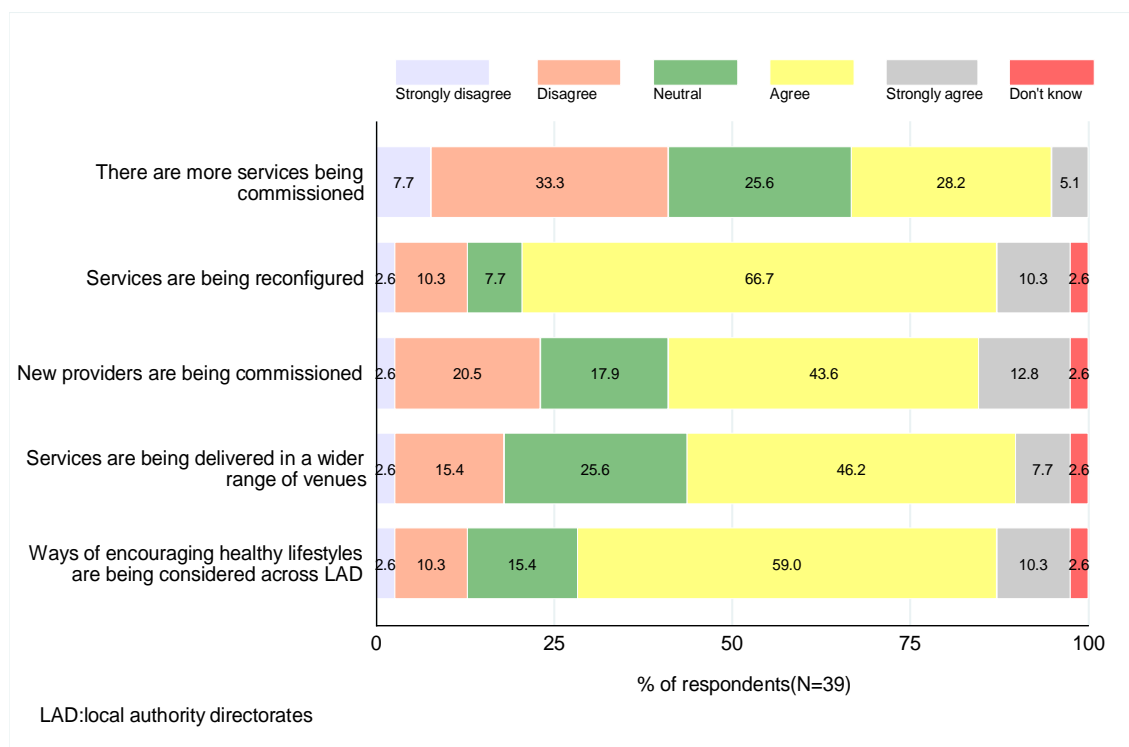
2.3.4 Adult lifestyle services and childhood obesity

One of the themes of the study concerns the impact of the reforms on services to promote healthy lifestyles and to address childhood obesity: section 4 of the survey (Q11-16) focused on these issues.

Healthy lifestyles in adults

Respondents were asked their views on each of the five statements listed in Figure 11. They agreed that the public health reforms had had impacts on services designed to encourage healthy lifestyles. In particular, services were being reconfigured and provided in a wider range of venues, and local authorities were commissioning new providers. Almost seven in ten respondents said that there was cross-directorate consideration of ways to encourage healthy lifestyles. However, only 33% of respondents agreed that more services were being commissioned.

Figure 10: Q11: What is your view of the following statements on services in your local area designed to encourage healthy lifestyles in adults since the reforms were implemented in 2013?



Comments

Few comments (between two and five) were received on each of these factors with the majority from DsPH. Three of the four DsPH who commented on whether *more services were being commissioned* highlighted the effects of cuts on services. Issues raised for other factors included the influence of budget cuts on reconfiguration of services, disinvestment leading to services not being re-commissioned, and ‘soft’

market testing to assess new providers. One DPH commented that ways of encouraging healthy lifestyles across local authority directorates had been encouraged since the reforms but 'needs to be stronger', while another argued that such initiatives were of long standing. One DPH gave the same response for all five factors, as follows:

We have commissioned services to encourage healthy lifestyle in a reduced budget envelope. This has encouraged service redesign which is a useful opportunity but we are currently reviewing how much we will be able to commission in the future budget scenarios.

A subsequent question requested more detail about who provided adult lifestyle services, summarised in Table 1. In total, 36 individuals responded to Q12. As this question was optional, the number of responses to each sub-question is provided in the bottom row. For both healthy eating and exercise initiatives, health trainers, local authorities and VCSE organisations were cited by between 33% and 69% of respondents; in relation to stop smoking services, GP practices, NHS Trusts and pharmacists were most often cited; VCSE organisations and NHS Trusts were most commonly mentioned for drug misuse (adults) and drug and alcohol misuse (young people) while GP practices, VCSE organisations and NHS Trusts were prominent for alcohol misuse. Almost 70% of respondents reported local authority provision of exercise schemes and 71% cited GP provision of stop smoking services.

Table 1: Q12: Who provided adult lifestyle services in 2014-15 in your local area?

	Healthy eating initiatives	Exercise schemes	Stop smoking services	Drug misuse services (adults)	Alcohol misuse services (adults)	Drug and alcohol misuse services (young people)	Weight management services
Not provided	11%	8%	.	.	.	6%	8%
VCSE	47%	33%	23%	54%	56%	51%	25%
Health trainers	61%	50%	29%	6%	11%	3%	42%
Private providers	6%	25%	9%	26%	28%	26%	36%
LA employees	47%	69%	37%	11%	6%	14%	39%
GP practices	22%	22%	71%	46%	47%	20%	28%
Employer workplace schemes	8%	22%	17%	.	.	3%	8%
Community groups	17%	8%	3%	9%	8%	6%	3%
NHS Trusts	31%	22%	66%	60%	64%	51%	44%
Pharmacists	3%	3%	66%	37%	17%	14%	8%
Volunteers	8%	11%	3%	11%	11%	3%	.
Don't know	3%
Number of respondents (N)	36	36	35	35	36	35	36

Almost half of respondents reported that lifestyle services could be accessed through an integrated health and wellbeing service (Table 2) and 42% of those 19 individuals believed this had increased utilisation of services amongst underserved groups. However, 40% of respondents were unsure about the impact of the integrated service, and this level of uncertainty was shared by both CCG and DPH respondents.

Table 2: Q13: Can lifestyle services be accessed through an integrated health and wellbeing service, and if so has this increased uptake among underserved groups?

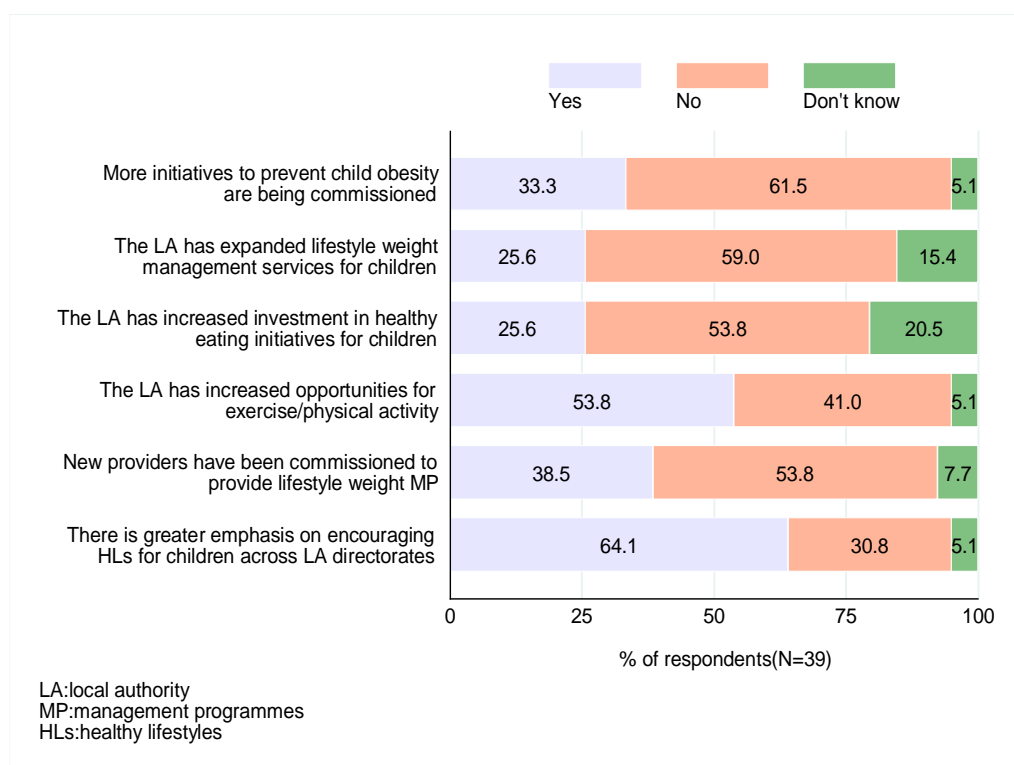
	Yes	No	Don't know	N
Can lifestyle services be accessed through an integrated health and wellbeing service?	49%	46%	5%	39
Has this increased uptake of services among underserved groups?	42%	16%	42%	19

Childhood obesity

The remaining questions in this section (Q14-17) were about the impact of the reforms on services reforms on services to address childhood obesity. Views on the impact of the reforms in relation to reforms in relation to six factors (see Figure 11) suggested that reforms had resulted in greater cross-directorate working within local authorities, which was similar to findings from the question about adult lifestyle services (see

Figure 10). There were also thought to be more opportunities for physical activity (54% of respondents). However, most respondents considered that the reforms had not led to more initiatives being commissioned in general, or specifically by the local authority in relation to healthy eating or weight management programmes or in relation to new providers. With one exception, 'don't know' responses were from CCG respondents.

Figure 11: Q14: Have the public health reforms led to changes in approaches to addressing child obesity in your local area in 2014-15?



Comments

There was more evidence of action and of changes in commissioning in respondents' comments on questions related to childhood obesity. Four of the seven respondents (six DsPH and one CCG respondent) who commented on whether *more initiatives were being commissioned* described additional initiatives including:

- additional funding for family initiatives supporting child health;
- decommissioning adult health trainers in order to commission child and family weight management services;

- early years nutrition advice in child care settings and through school programmes.

A DPH noted the discontinuation of the Healthy Schools Programme prior to 2013, due to budget restraints and another commented on the inadequacy of current services.

As to whether there had been an *expansion in lifestyle weight management services* for children, three of the DsPH who commented had developed such services, through providing more healthy eating initiatives for children, through decommissioning adult health trainers (as mentioned in responses to the previous question) and through re-commissioning of services (not specified).

Four DsPH provided comments on the question of whether there were *increased opportunities for exercise/physical activity*, and the following initiatives were cited:

- increased investment in free ‘lifestyle passes’ for under 17s (through public health funding) (two respondents);
- leisure ‘universal offer’.

However, one DPH noted that the public health budget had picked up costs for existing leisure services.

No specific examples were provided of *new providers of lifestyle weight management services* or of *changes in promoting healthy lifestyles for children across local authority directorates*. However, one DPH emphasised that the local authority had developed an integrated approach rather than separate services as implied in the survey questions.

When asked a subsequent question (Q15) about the provision of exercise schemes and healthy eating initiatives to tackle childhood obesity (Table 3), a minority of respondents reported that their local authority had not provided exercise schemes (10%), or healthy eating initiatives (8%), or neither service (8%).

Five respondents– all CCG respondents – did not know what types of service had been commissioned in their local area.

Table 3: Q15: In 2014-15 which types of services were commissioned to specifically tackle child obesity?

	Not provided	School-based	Advice to parents	Advice to children	Family-based	Don't know
Exercise schemes	10%	51%	54%	44%	54%	13%
Healthy eating initiatives	8%	59%	59%	36%	56%	13%
Number of	39	39	39	39	39	39

respondents (N)

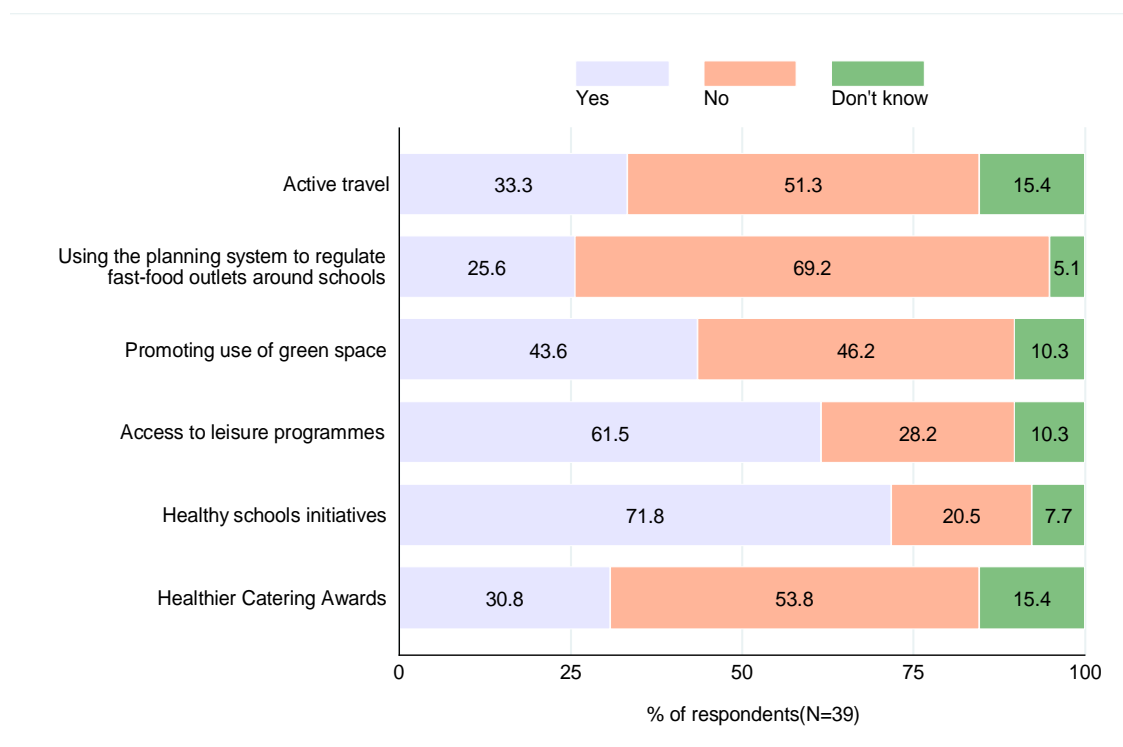
When asked about providers of services for preventing childhood obesity and helping overweight children (Q16), the diversity of providers was evident (Table 4). This question was optional, so the number of respondents is also reported (in total, 35 individuals responded to Q16). The number of responses to each sub-question is provided in the bottom row. Provision was most often through school nursing services and NHS Trusts.

Table 4: Q16: Who provided services for preventing child obesity and helping overweight children and young people in 2014-15 in your local area?

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

The survey tried to identify broader approaches to addressing child obesity through travel, planning regulations, use of green space, leisure programmes, healthy schools initiatives and healthier catering awards (Figure 12). Over 70% of respondents reported that their local authority had funded healthy schools initiatives following the public health reforms and over 60% reported that the local authority had provided funding for improving access to leisure programmes. However, using the planning system to regulate fast-food outlets around schools was less common (26%).

Figure 12: Q17: Taking a broader approach to addressing obesity in children, have the reforms led to funded initiatives in your local authority in 2014-15 in the following areas?



Comments

In comments on this question, it was emphasised that many such initiatives predated the reforms. In relation to *active travel*, (seven DsPH and one CCG respondent) five of the eight respondents considered initiatives were already in place, while three respondents cited changes since the reforms, including 20mph speed limits and improvements in walkways/footpaths and cycling and reduction in school runs. The same pattern was evident for *use of green space* (already in place in the views of three of the four respondents) although one DPH noted that planning laws which allowed too much development on green space ran counter to public health needs.

In relation to *using the planning system to regulate fast food outlets* (11 responses from DsPH) only one respondent thought they were already in place and six were in the process of developing/discussing changes. For the five DsPH who commented on initiatives, examples included:

- a 400 metre exclusion zone around schools' also applying to fast food mobile service vans (e.g. burger van, mobile fish and chips);
- working with district councils;
- developing planning guidance;
- developing specific supplementary planning guidance for health;
- raising council motions.

One DPH considered that national changes to the planning laws were required for this to be effective and another noted that, as an upper tier authority, this was outside their jurisdiction.

For *leisure programmes* (four DPH responses), there were examples of free passes for under 17s and leisure facilities being made more accessible for people with disabilities. In relation to *healthy schools*, while it was pointed out the Healthy Schools initiative had been formally disbanded there were examples of schools funding health initiatives and of commissioning 'a whole school approach to building resilience'. For '*Healthier Catering Awards*', there were no examples provided of changes since the reforms, although one DPH described this as in the planning stage.

Respondents were asked to identify any missing initiatives and one DPH highlighted a community parenting programme that had been commissioned.

2.3.5 Identifying innovative practice

The fifth set of questions (Q18-19) was designed to identify how innovation was defined and encouraged and whether there were examples of innovative practice. The first question in this section asked respondents an open question – to briefly define innovation.

All thirty nine survey respondents commented on this question and there was a wide range of responses: most could be grouped (singly or in combination) into the following categories: asset and place-based approaches; cost-effectiveness; cross-directorate and multidisciplinary working (for example, involving housing, transport and the fire service); and specific examples. Respondents used common terms to describe innovation, such as 'new models of delivery', 'new ideas', 'simplicity' and 'creativity' (including in tendering and procurement). There were statements associating innovation with importing best practice and understanding system complexity and the potential for transformation. The following main themes emerged.

Asset-based approaches

Seven respondents (four DsPH and two CCG respondents) identified the importance of ground-up, 'customer-focused' and asset-based approaches, focusing on community resilience and co-production and, in the words of one CCG respondent 'changing the power dynamic'. In two cases, this was also combined with achieving better value for money, as a DPH noted:

Working with local communities to better understand their assets and what will work for them, to get the best value for money.

Working across directorates

Four respondents (three DsPH and one CCG respondent) cited working across local authority directorates: this was seen by one DPH as encouraged by the reforms and by another as necessary due to the cuts. The latter DPH commented:

The dire financial circumstances of most LAs means that fewer bespoke PH services are being provided or commissioned and the PH grant is being used to prop up ... services that would otherwise have to be cut. This is leading to an increased emphasis on trying to bend the mainstream spending of LAs to get more health gain for the population.

Effectiveness and efficiency

Effectiveness and efficiency were also specifically cited by five respondents (four DsPH and one CCG respondent), to be achieved through redesign of services or using existing resources differently to achieve desired outcomes. One DPH noted that 'dwindling resources' meant that the VCS would be encouraged to 'step in with a different approach'.

Specific topics/approaches

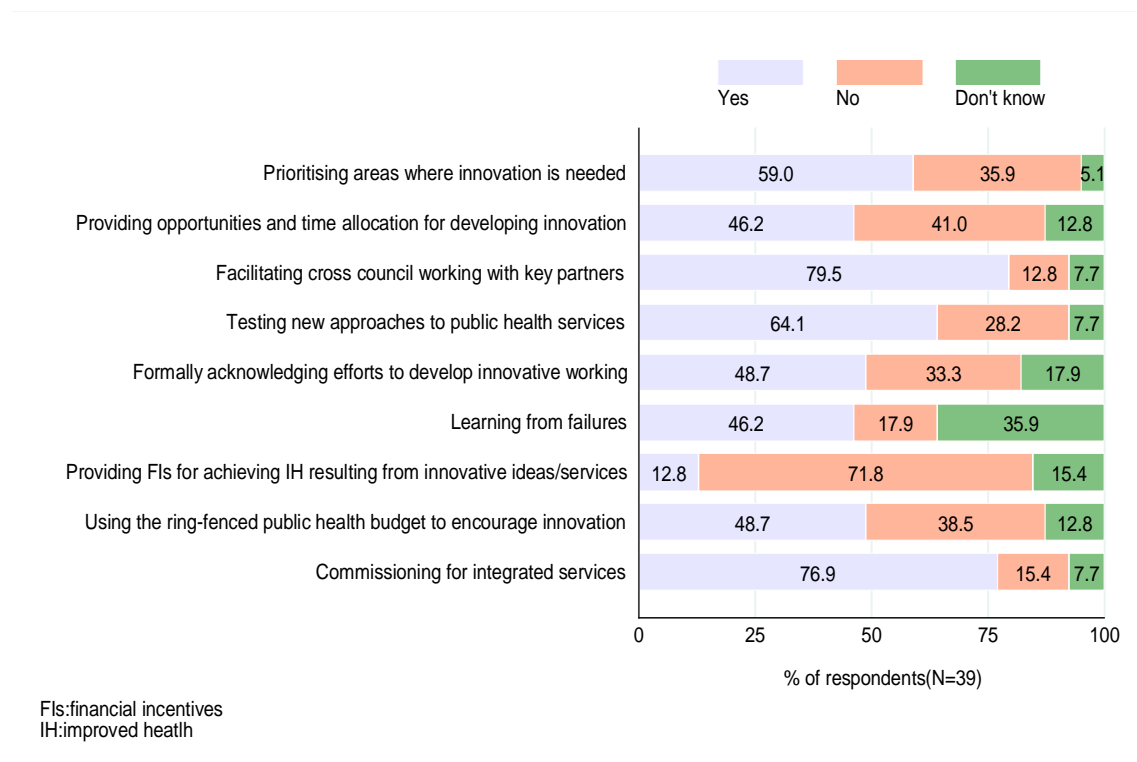
Specific topics mentioned were locality mapping to identify local services and gaps (two CCG respondents); working across populations rather than individuals; joint working across fuel poverty and healthy child initiatives; exercise on prescription; integrated preventive services; and commissioning private providers to provide services to address obesity.

A number of caveats were raised: innovation was described as being defined in different ways across local authorities and improvement was required not just in local innovation but also in appropriate action and leadership by national government. As reflected in their responses to earlier questions, innovation was seen as independent of the reforms by three respondents (two DsPH and one CCG).

A subsequent question asked respondents whether the local authority had created a climate for developing innovative approaches across a range of different areas (see Figure 14), such as prioritising areas where innovation was needed, providing time for, or rewarding innovation, facilitating cross-directorate working, using the public health budget to encourage innovation, and developing integrated public health services. Responses were largely positive: sub-group analysis by type of respondent showed that CCGs were less likely to provide definitive answers (i.e. 'don't know' responses were more frequent than for DsPH). Amongst the 28 DsPH who responded to the survey, 89% considered cross-council working had been facilitated and 82% said that the local authority had commissioned integrated services. The provision of financial incentives for improving health outcomes was rare (82% responded 'no').

Figure 13 shows responses pooled across CCG and DPH respondents (n=39).

Figure 13: Q19: Has your local authority created a climate for developing innovative approaches to public health by doing any of the following?



Comments

There were a few comments/examples for each of the factors listed above (between one and five, with most comments from DsPH). Specific examples included the following:

- digital innovation to support underserved groups;
- away days for developing innovation;
- multi-agency community wellbeing partnership chaired by the DPH to facilitate cross-council working with key partners;
- social marketing programme to facilitate cross-council working with key partners;
- award for innovation to acknowledge innovative working;
- new approaches to public health services being developed;
- re-tendering of services to encourage new approaches (from a CCG respondent);
- robust evaluation of new initiatives;
- using the ring-fenced budget to encourage innovation through a grant process and 'soft' market-testing.

In relation to commissioning for integrated public health services, there was an example of a 'prime provider' for drug and alcohol services and of integrated approaches across lifestyle and sexual health services and substance misuse.

One DPH noted that they were waiting for the health premium to be introduced in order to develop incentives for achieving improved health through innovation.

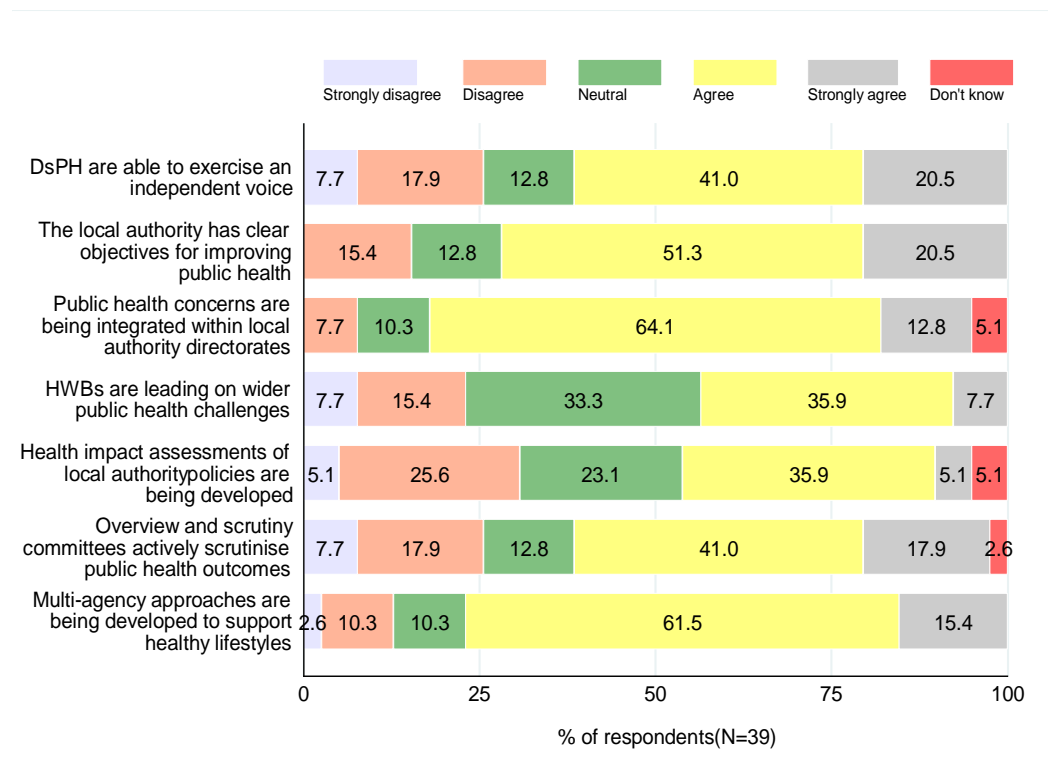
2.3.6 The public health leadership role of local authorities

Section 6 of the survey (Q20) was concerned with the public health leadership role of local authorities, including the extent to which DsPH could exercise an independent voice, the public health objectives of the local authority, including multi-agency approaches, the leadership role of HWBs in wider public health challenges, the use of Health Impact Assessment (HIA) and the role of the Overview and Scrutiny Committee (OSC) in scrutinising public health outcomes.

Respondents were asked their views on the statements listed in Figure 15 in relation to the public health leadership role of their local authority. Except for statements relating to the leadership role of HWBs and the use of HIA, all the statements had more than 50% 'agree'/'strongly agree' answers.

CCG respondents were more likely than DsPH to express a neutral view and were also more likely to give a 'don't know' response. When asked whether DsPH could exercise an independent voice, 75% of DPH respondents agreed or strongly agreed, but the corresponding figure for CCG respondents was just 27%. The majority of CCG respondents agreed with the statement that HWBs exercised a leadership role for public health challenges, while the majority of DsPH indicated a neutral opinion.

Figure 14: Q20: What are your views on the following statements in relation to the public health leadership role of your local authority?



Comments

Four respondents (three DsPH and one CCG respondent) commented on whether the DPH could *exercise an independent voice*. While the DPH annual report and leadership for public health across the borough were mentioned by one DPH, others were sceptical with one DPH commenting 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 commenting 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’.

In an additional comment on this section as a whole, one DPH noted:

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.

As to the question of whether local authorities had *clear objectives for improving public health*, two out of four DPH respondents commented that this was led by the DPH/public health team, while a CCG respondent noted that local authority priorities were not always evidence-based or in line with other commissioners in areas such as mental health. However, one DPH cited a signed public health pledge by the council and another that clear objectives were reflected in the Council Plan and the HWB strategy. Two DsPH highlighted *integrated approaches across local authority directorates*, including the use of HIA, Health Equity Assessment (HEA) and Social Return on Investment (SROI) to influence decision-making. A DPH noted that:

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

In response to a specific question on whether *HIA of local authority policies was being developed*, one DPH noted that HIA had been carried out, another that it had been discontinued while a third noted that it was under development. A CCG respondent was not aware of any evidence related to HIA.

Five respondents (three DsPH and two CCG respondents) commented on the *role of the HWB in leading on wider public health challenges*. Two respondents saw the role of HWBs as developing but two respondents were more critical. One DPH described how its scope was limited by its membership; another described it as ‘almost an ‘irrelevance’; while a CCG respondent noted:

HWBs are ineffective under present governance arrangements i.e. council committees and statutory members versus non-statutory.

However, there were two examples of wider issues being considered by a HWB, namely fluoridation of water and air quality (as a result of pressure by the DPH).

Multi-agency approaches to support healthy lifestyles were noted by two DsPH (in one case the example cited was based on Vanguard and Pioneer initiatives).

Three out of five respondents (all DsPH) commented favourably on *the role played by OSCs in scrutinising public health outcomes*, with one DPH commenting on a 'fantastic set of scrutinies on these issues'. (Two respondents were neutral).

In response to a question over specific initiatives reflecting a public health leadership role, the following examples were given by DPH respondents:

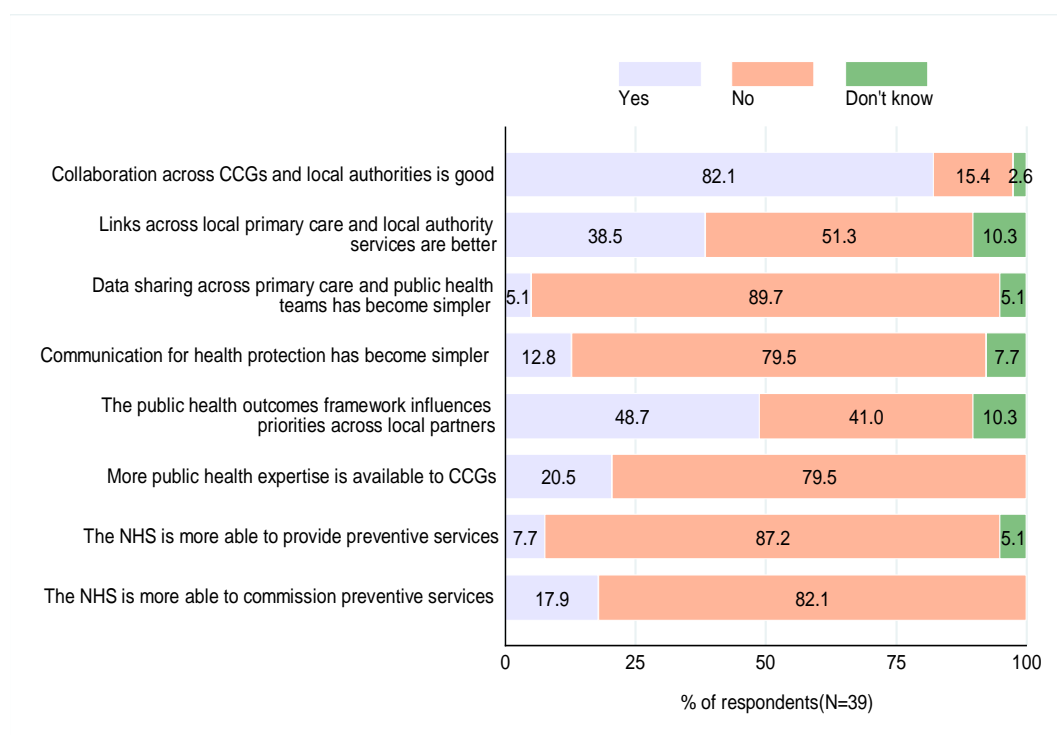
- DPH reports to the Chief Executive Officer and there is a dedicated cabinet member;
- each local authority directorate has a named public health lead;
- very active on social media channels;
- focus on air quality as a result of public health raising and pushing the issue.

2.3.7 Changes in the public health system

Section seven of the survey (Q 21-24) investigated the impact of the reforms on various aspects of a public health system: collaboration across CCGs and local authorities and across local primary care and local authority services; data sharing; communication for health protection; the impact of the public health outcomes framework; and the role of the NHS in providing preventive services. This section also asked questions over enablers and barriers to improving health outcomes and the support required by public health commissioners (see 2.3.8 and 2.3.9 below).

Respondents were asked their opinions on the statements presented in Figure 15 in relation to the public health system in their local area since the public health reforms. Collaboration across CCGs and local authorities was considered good by most respondents (82%) but there was less support for the statement that links between GP practices and local services were better (39%). When asked whether the public health outcomes framework influenced priorities across local partners, the percentage of 'yes' and 'no' answers was similar (49% vs. 41%) although the difference was larger for the sub-group of DsPH responses (54% vs. 39%, data not shown). According to the 39 individuals responding to the survey, the reforms had neither made data sharing across primary care and public health simpler (90% of respondents), nor simplified communication for health protection (79%). Respondents (over 80%) disagreed that the NHS was more able to provide or commission public health services and also disagreed that more public health expertise was available for GPs.

Figure 15: Q21: What are your views on the following statements in relation to the public health system in your local area since the reforms?



Comments

These results are reflected in respondents’ comments. In relation to *data sharing*, all ten respondents considered the situation had worsened since the reforms. One DPH 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 PH teams’.

Of the eight DsPH who commented on whether more *public health expertise was available for CCGs*, five considered that there had been a loss of public health expertise, with one DPH describing it as a ‘massive loss in healthcare public health expertise’. The remainder saw it as about the same or working well.

In response to questions on whether the NHS was more able to *provide and commission preventive services* (eight responses for each (seven DsPH and one CCG respondent)), all respondents commented on the reduced role of the NHS. One DPH commented that ‘they expect local government to fund them [preventive services] instead and don’t see it as their responsibility’. A CCG respondent noted that ‘it’s all about the frail elderly and preventing admission’.

Ten respondents (nine DsPH and one CCG) provided comments on *collaboration between CCGs and local authorities*. Five DsPH considered collaboration good and three DsPH described an improving situation. Two DsPH described relationships as very good, in one case citing CCG investment in three major programmes and joint commissioning arrangements, and in another case developing co-commissioning approaches and joined up work in Vanguard sites and integration Pioneer sites. The

other three respondents (two DsPH and one CCG respondent) were more critical, with the CCG respondent noting that ‘the political tends to trump the health need’ with money being removed from CAMHS, and drug and alcohol services. In relation to *collaboration at a local level across primary care and the local authority*, three DSPH saw no change, and one CCG respondent described a deterioration.

The public health outcomes framework had limited impact according to respondents (four DsPH and one CCG respondent) A DPH noted that ‘it has had the adverse effect of making prevention nobody else’s business’ and a CCG respondent noted that ‘CCGs and LA still not truly working to this and JSNA still inadequate’.

In response to the question whether *communication for health protection* had become simpler, (eight DsPH and one CCG respondent) it was described as ‘about the same’ or working well by two DsPH. The other seven respondents considered that communication had not got simpler: it was described as ‘worse’ (two DsPH and one CCG respondent); ‘fragmented’ (two DsPH) ‘confusing and quite frankly a risk’ (DPH); and as being less clear where responsibilities lay (DPH) .One DPH considered that communication with PHE could be improved.

2.3.8 Enablers and barriers to achieving better health outcomes

All 39 respondents responded to open questions on enablers and barriers to achieving better health outcomes in their local area.

The barrier most commonly raised (18/28 DsPH and 4/11 CCG respondents) 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, 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. Related issues were a lack of time and manpower.

Barriers to achieving better public health outcomes were described at both national and local authority level. One DPH described a lack of national action on alcohol, tobacco, salt and fat, the impact of national policies on unemployment and use of food banks and changes in the policy on green issues. Other DsPH noted barriers arising from competing messages from ‘big business’; the need for ‘cross-governmental policy development across the Department for Communities and Local Government and DH’; an emphasis on lifestyle factors rather than on wider determinants of health; and an emphasis on ‘sharp end’ services rather than on prevention. At a local authority level, seven DsPH described failings, including 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 a DPH 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’.

Specific issues were raised with regard to the public health workforce and public health leadership: two DsPH cited a lack of public health leadership and one described a problem locally in recruiting consultants in public health.

Moreover, the reforms had led to a loss of experienced public health staff and there were difficulties in accessing data. Fragmentation of the local health system was mentioned in relation to lack of access to data (two DsPH); fragmented commissioning across public health and the NHS (two CCG respondents); and a DPH cited 'uncertainty of geographical unit of planning and influence'. 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.

Other issues included the lack of a three-year planning cycle and the 'lack of good data for health and social care outcomes or benchmarking that is 'fit for purpose''.

Some barriers in achieving outcomes were attributed to the 'complexity and intractability' of public health problems and difficulties in engaging with those most affected (four DsPH), due to a lack of aspiration in parts of the community; the 'inability to understand how to improve this for people suffering from poverty and alienation'; and 'difficulties of engaging those most affected'.

Some of the enablers highlighted by respondents reflected the converse of barriers, such as availability of funding, the role of national government in prevention, a ring-fenced grant that was protected and audited (two DsPH) and which also reflected the level of intervention required to make a change. In particular, community engagement and co-production with a move away from a medical model was, as one DPH put it, 'an integral part of an overall approach to wellbeing'. Foremost among the enablers mentioned was the quality of relationships, (11 respondents (six DsPH and five CCG respondents)), whether between individuals, across the local authority and public health teams or across partners and wider stakeholders. One DPH commented on the 'genuine cooperation' needed across the council, the CCG and local NHS providers. 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 DsPH). Joint commissioning, devolution and the NHS Five Year Forward View (5YFV) were also described as enablers.

HWBs were mentioned by six respondents (five DsPH and one CCG respondent) in relation to their role in leadership and in developing a shared vision, but were also described as needing to mature and to focus more on the scrutiny of public health outcomes. The role of councillors as enablers was mentioned by three DsPH, with one commenting that the 'local cabinet portfolio holder is a great advocate'.

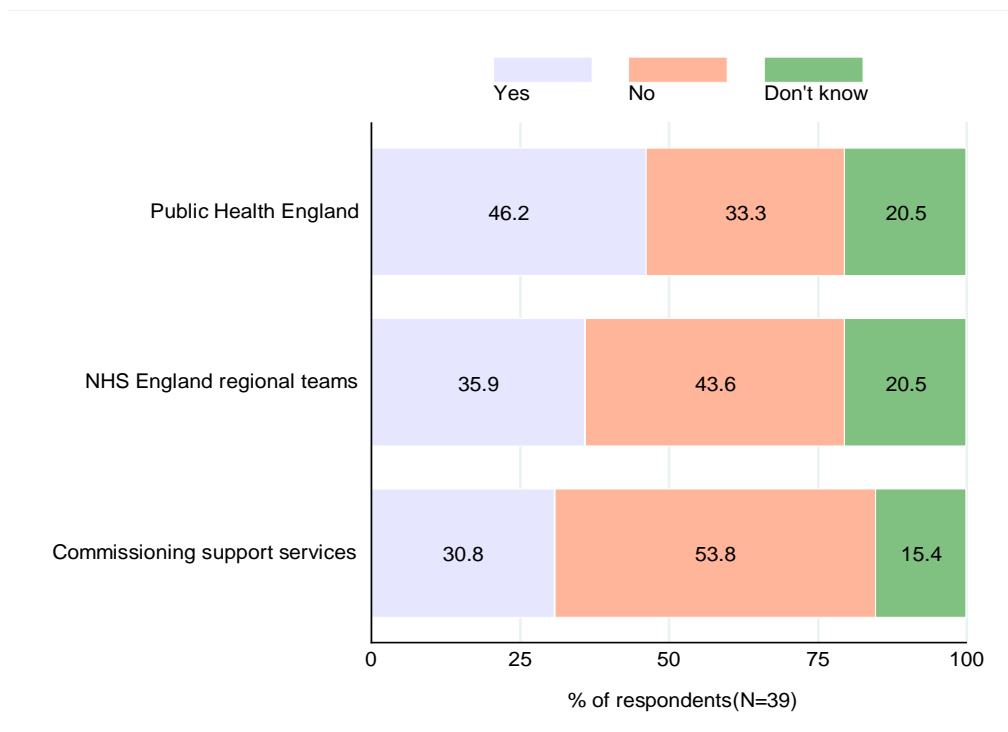
Other issues mentioned included economic modelling with a better understanding of return on investment, especially on the part of CCGs; capacity building through ‘making every contact count’ through front-line services; and developing consensus over a place-based approach. A DPH noted that ‘in less desperate times’ the relocation of public health into local authorities could itself be considered an enabler to improving health outcomes.

2.3.9 Support for public health commissioners

The survey tried to identify whether additional support was needed by public health commissioners from PHE, NHS England regional teams or commissioning support units (CSUs), (Figure 16).

Respondents’ views were mixed. The need for additional support from PHE was felt more keenly by CCG respondents (64%) than by DsPH (39%), but 36% of respondents in both groups expressed the need for more support from NHS England regional teams, while only 31% of respondents indicated that additional support was needed from CSUs. However, CCG respondents were less sure than DsPH whether commissioners needed additional support (‘don’t know’ responses from CCGs ranged from 36% to 45% (n=11); for DsPH, the corresponding figures were 7% to 14% (n=28)).

Figure 16: Q24: Do public health commissioners in your local area need additional support from the following?



Comments

Fourteen respondents (13 DsPH and one CCG respondent) commented on whether additional support was needed by public health commissioners from PHE: six DsPH thought no further support was needed and three of these saw the value of PHE as lying mainly in health protection. A DPH considered that support 'could cause confusion ... and is set to do so where they want to commission at scale without taking into account local arrangements'. However eight respondents (seven DsPH and one CCG respondent) provided examples of where further support could be useful, including the following:

- evidence reviews/data analysis;
- cost-effectiveness analysis/supporting investment in public health, including analyses of return on investment;
- sharing innovation/best practice, including links to working with the wider system and national initiatives;
- strategic support for having robust public health teams;
- more localised and timely intelligence;
- advice on commissioning decisions (such as awarding contracts);
- improving access to public health data;
- coordination with NICE.

Ten respondents (nine DsPH and one CCG respondent) commented on support from NHS England and eight respondents considered further support would be useful. Four DsPH considered that NHSE was no longer as 'visible' locally or was difficult to engage with. Three DsPH provided examples of where input had been helpful, namely: health visitor transfer; uptake of immunisation and vaccination across public health and CCGs; and child protection services. Other DPH respondents commented on the need for access to more localised and timely data, the development of a more consistent framework and an approach to prevention with 'a joint discussion between DsPH and NHS England with effective local devolution', while a CCG respondent noted the need for support for moving upstream in prevention and 'to a three-year financial target'.

Thirteen respondents (10 DsPH and two CCG respondents) provided comments on support from CSUs, nine of whom considered further support would be helpful, citing examples such as incident management, clinical governance and clinical audit (including risk and contract management). The two CCG respondents noted that they no longer used external CSUs and five DsPH described the need for quicker responses and speedier access to data.

Sources of support additional to the three areas described above were cited by four DsPH, two of whom noted the need for access to data from the Health and Social Care Information Centre (HSCIC). One DPH claimed that lack of access to this source of data was hampering the provision of support by public health to CCGs on population health needs. Greater focus on local implementation issues by PHE and additional support from academic public health centres were also cited.

2.3.10 Comments on the survey and further areas to consider

Respondents made the following comments on the survey:

- Structure: the survey was too long (two DsPH) and geared towards unitary or metropolitan councils (one DPH));
- Content: the survey did not recognise the extent of public health involvement in local authorities before the reforms (one DPH));
- Relevance: given imminent cuts to the public health budget the survey would soon be out of date (one DPH).

Further comments by respondents

- Two DsPH emphasised that the move to the local authority was beneficial although the rest of the reforms had resulted in a more fragmented NHS.
- The ring-fenced grants did not reflect reality.
- Public health staff needed different training to prepare them for working in a local authority context.
- Impact could not be demonstrated in such a short period of time and two CCG respondents considered that threats to budgets 'dominated thinking'.
- There should be greater emphasis on the context of resources available locally and on disinvestment in existing services given limited financial room for manoeuvre. One DPH commented:

The key challenge for PH at the moment is to get sufficient headroom to develop new approaches by re-specifying or recommissioning high-spend services to allow for innovation and new forms of delivery.

3. *Strengths and limitations*

The national survey was 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 survey provided useful information on each of these aspects and, in particular, respondents provided extensive comments which were the subject of qualitative analysis. The national survey forms part of the scoping phase of the study, is intended to inform case study research and findings should not be viewed in isolation from other elements of the scoping phase or the wider study. While the survey targeted two groups - CCG members of HWBs and DsPH - separate surveys were carried out of local Healthwatch and VCSE members of HWBs and of VCSE organisations involved in providing preventive services. Case studies include a wide sample of interviewees and different perspectives will therefore be captured by the research project as a whole. The survey was carried out in August 2015 and therefore does not reflect changes in policy and in the public health budget since that date.

The main limitation concerns the low response rate for the survey. While all regions of England were represented, the response rate was disappointing, especially for CCG members of HWBs (7.2% (11/152)). The response rate for DsPH was 20.7% (28/135). There is a risk that our findings are biased – although we can neither prove nor disprove this. 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 numbers of respondents for each figure and the actual numbers for both CCG and DPH respondents where comments are reported.

A further limitation is the difficulty of assessing the impact of the public health reforms in isolation from a reduction in the public health budget (2015/16) and reduced funding to councils since 2010. Local authorities differed in levels of public health investment, partnership arrangements and involvement in public health prior to the reforms and these factors, combined with transfers of public health funds which reflected historical levels of public health spend in the former Primary Care Trusts, influence the extent of current activities irrespective of the reforms.

4. Discussion

This national survey forms part of the scoping phase of the study, intended to inform case study research. It will be repeated in summer 2016 in order to explore changes over time, and we will consider how to improve response rates for the second round. We plan to retain topics addressed in this survey, but may include additional questions where relevant (e.g. on the Health Premium Incentive Scheme).

Results demonstrate a range of views in response to most questions, reflecting the variation of approaches across the local authorities which were represented. The ranges identified in the survey, therefore, capture the *minimum* variation in views and in practice that exist nationally. While the public health leadership role of local authorities and their support for innovation were viewed positively by the majority of respondents, reflecting broad support for the relocation of public health responsibilities, most of the 39 respondents did not consider the reforms had impacted positively on health protection or data sharing: 79% disagreed that communication about health protection had become simpler and 90% thought the reforms had not simplified data sharing (100% of the 28 DsPH expressed this view).

The survey showed support for retaining a public health budget, while also reflecting the view that it did not reflect the sum total of public health spend and that more transparency and better auditing were needed. Only one third supported preserving the distinction between mandated and non-mandated public health services, with respondents commenting on the lack of an evidence base to support the distinction and problems of emphasising measurement rather than action. The budget was widely used to support public health across local authority services (87% of respondents) but under half of respondents (39%) reported that top-slicing had taken place in 2014-15. This result can be compared with results of a survey of core HWB members, carried out in late 2014 as part of a School for Public Health Research (SPHR)-funded study on prioritising investment in public health (unpublished), which asked questions related to the ring-fenced budget (2013-4). In this survey, a smaller percentage of respondents (20%) considered that the ring-fenced budget had been top-sliced in 2013-14 while 64% considered that the ring-fenced budget had been used for public health activities across local authority directorates.

Despite some reservations over the distinction between mandated and non-mandated public health services, most respondents considered funding to be adequate for mandatory functions, such as the National Child Measurement Programme and NHS Health Checks. However, about half of respondents considered that public health funding was inadequate for services to address alcohol misuse, obesity in children and adults, or for promoting exercise for children. In contrast, over two thirds considered stop smoking services to be adequately funded. This raises questions over the extent to which non-mandatory elements of the budget will be prioritised, despite their public health importance.

Pooling of public health funds across CCGs and local authorities was uncommon, but the areas where this most often occurred were adult exercise schemes, substance misuse and prevention of excess winter deaths.

In relation to community involvement in commissioning, there was perhaps less change than might have been anticipated following the reforms. Although increased community participation was anticipated, whether in identifying local priorities, community capacity-building, influencing the kinds of services commissioned or in the co-design of services, the majority of respondents identified little overall change. Identifying local priorities and influencing service commissioning were least often considered to have increased. However, in related areas of developing closer links to communities, asset-based approaches, developing new integrated health and wellbeing services or working with underserved groups through the VCSE sector, a majority agreed that such approaches had been encouraged by the reforms. In particular, new integrated health and wellbeing services were being developed.

In relation to providers of preventive services, for each category of provider, respondents were more likely to report that the level of involvement in providing preventive services had stayed the same, perhaps reflecting inherited contractual commitments. However, over one third of respondents identified greater involvement of volunteers, VCSE organisations, local authority employees and pharmacies since the reforms. Reductions in the use of health trainers and NHS Trusts in providing preventive services were reported by almost a third of respondents, but around two thirds reported that levels of provision by private providers and GPs had stayed largely the same. Combinations of VCSE organisations, health trainers and local authorities were more prominent for healthy eating and exercise initiatives, whereas GPs, pharmacies and NHS Trusts were most often reported as involved in stop smoking services. VCSE organisations and NHS Trusts remained prominent for substance misuse services.

The survey showed that lifestyle services were being reconfigured and provided in a wider range of venues, and that local authorities were commissioning new providers. The majority reported cross-directorate consideration of ways to encourage healthy lifestyles. However, only one third of respondents considered that additional services were being commissioned. In particular, a majority of respondents considered that the reforms had not led to more services being commissioned by the local authority in relation to healthy eating or weight management programmes to address childhood obesity.

For broader approaches to addressing childhood obesity, such as planning regulations, use of green space, leisure programmes, healthy schools initiatives and healthier catering awards, over 70% of respondents reported that their local authority had funded healthy schools initiatives and over 60% reported funding for improving access to leisure programmes. However, using the planning system to regulate fast-food outlets around schools was much less common (26%). The latter finding tallies with a survey of lead members for public health by the LGA (2015d), where public health was considered less embedded across licensing, planning, housing and transport. As two-thirds of respondents in our survey reported greater cross-directorate working to encourage healthy lifestyles in children, analyses of the effect of the reforms will need to recognise that improved outcomes may be due to initiatives commissioned outside of the public health grant.

The survey explored how innovation was defined or encouraged and whether there were examples of innovative practice. Main themes included the development of asset-based approaches; cost-effectiveness; and cross-directorate and multidisciplinary working. Most considered that councils had provided a context for encouraging innovation through, for example, testing new approaches, facilitating cross-directorate working, using the public health budget to encourage innovation or rewarding innovative practice. However, there was little evidence of financial incentives being used in this context.

Views of the public health leadership role of local authorities were explored through a series of statements covering topics such as the role of the DPH, the adoption of clear public health objectives on the part of local authorities, integration of public health concerns across directorates, the use of HIA, the role of the HWB, and of OSCs. With the exceptions of the leadership role of HWBs and the use of HIA, over half of respondents held positive views of changes since the reforms. While collaboration across CCGs and local authorities was considered good by most respondents (82%) there was less support for the statement that links between GP practices and local services were better (35%). However, as mentioned above, a more critical response was evident in views of the public health system in relation to data sharing across primary care and public health and communication for health protection. Respondents' written comments on these questions revealed that, in some areas, the position in both situations had actually worsened since the reforms. The involvement of the NHS in providing or in commissioning public health services had lessened and it remains to be seen whether the NHS 5YFV will serve to change this balance. The availability of public health expertise for CCGs had not increased, according to over 80% of respondents. A worsening trend is suggested by comparison with results of the earlier survey carried out as part of the SPHR-funded project, mentioned above, where 55% of respondents considered that there was less public health expertise available to CCGs since the reforms.

In relation to the question of whether commissioners needed additional support (from PHE, NHS regional teams and CSUs), answers were fairly evenly balanced, but more than half of respondents did not consider additional support was needed from CSUs.

In responses related to enablers and barriers to improving health outcomes, budget restrictions figured prominently. 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.

Key enablers included trust, the quality of relationships and degree of commitment to public health priorities. Leadership from public health teams was important; front-line local authority services could make 'every contact count'; and local authorities were best placed to develop place-based approaches to public health. Moving towards community engagement and co-production was seen as fundamental to promoting wellbeing. While HWBs played an important role, they required further maturation and more emphasis on

scrutinising public health outcomes. Surprisingly, the role of councillors as advocates and enablers was mentioned by only three respondents.

In conclusion, our survey results have provided a useful baseline for assessing the impact of the reforms and for informing interview schedules for case study research. Results will also provide a useful context for interpreting national data on the deployment of the ring-fenced public health budget. A report on innovation, planned for August 2016, will draw on relevant aspects of all four research reports carried out as part of the scoping phase of the study.

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Appendix one: survey questions

See attached PDF for details.