

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

**Results from first phase fieldwork in ten case study sites across England**

**Research Report 5**

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Disclaimer

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# Abbreviations

BME: Black and Minority Ethnic

CAMHS: Child and Adolescent Mental Health Services

CCG: Clinical Commissioning Group

CE: Chief Executive

DCLG: Department for Communities and Local Government

DH: Department of Health

DsPH: Directors of Public Health

HIA: Health Impact Assessment

HWB: Health and Wellbeing Board

JHWS: Joint Health and Wellbeing Strategy

JSNA: Joint Strategic Needs Assessment

LGA: Local Government Association

NHS 5YFV: NHS Five Year Forward View

NHSE: NHS England

NIHR: National Institute for Health Research

ONS: Office for National Statistics

PCT: Primary Care Trust

PHE: Public Health England

PHOF: Public Health Outcomes Framework

PRP: Policy Research Programme

SPHR: School for Public Health Research

VCSE: Voluntary, Community and Social Enterprise

VONNE: Voluntary Organisations’ Network North East

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# Executive Summary

## Background

This report is the fifth in a series of research reports arising from a Department of Health (DH) Policy Research Programme (PRP) - 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 deployment of the ring-fenced public health budget, commissioning and providing preventive services and the new public health role of local authorities. This report presents the results of first phase fieldwork in ten case study sites across England. Interviews carried out across the case study sites explored:

* Changes in roles and responsibilities;
* Views of the public health reforms;
* How public health services are being funded and changes in how the public health budget is being used over time;
* How preventive services are being commissioned and provided and their impact on health inequalities;
* Innovative approaches to promoting health and narrowing health inequalities;
* How commissioning is taking place across the new public health system;
* How local authorities are developing their leadership role in improving health and addressing health inequalities.

Follow-up interviews with a sub-sample of interviewees will take place towards the end of 2016.

## Methods

Selection of ten case study sites was informed by the scoping phase of the study. Case study sites reflect different levels of deprivation, a wide geographical spread and differences in political control. Each region of England is represented, with the exception of the North East (three sites were approached but refused to participate) and there are three multi-district authorities.

Fieldwork began in October 2015 and was completed in May 2016. Between seven and 12 interviewees participated in each site. Interviewees included statutory members of Health and Wellbeing Boards (HWBs), the Chief Executive (CE) of the local authority, a representative of the Voluntary, Community and Social Enterprise (VCSE) sector, the Chair of the Health Scrutiny Committee and a District Council representative on the HWB (for multi-district authorities). A second elected member of the HWB was invited, depending on whether the portfolio held by the HWB Chair included public health. Where the VCSE sector was not represented on the HWB, a representative from a local umbrella body was invited to participate.

Where possible, interviews were carried out face to face. Interviews were recorded with the permission of the interviewee and transcribed verbatim by an external transcription agency. Analysis of transcripts was carried out by two members of the project team.

## Results

Results are presented for ten key themes, reflecting research questions arising from the three workstreams of the study.

*Views of the public health reforms*

The reforms were widely welcomed. They reflected the importance of wider determinants of health, cross-directorate working and whole systems approaches and meant that public health staff were more closely linked to the place-shaping role of local authorities, to elected members, and community networks. Integration of children’s services was also welcomed. However, austerity was described as ‘derailing’ the reforms and the public health budget was at risk. Questions were raised over the role and sustainability of the public health profession, and the importance of contextual and participative approaches to understanding and implementing the public health evidence base was emphasised. The transfer to local authorities had been a ‘culture shock’ for public health teams in some sites, with a perceived lack of influence and political credibility and a degree of fragmentation in commissioning preventive services. There was a trade-off for the profession between central control (but greater professional autonomy) in the NHS and local flexibility (but often a reduced status) in the local authority.

*Organisational models and accountability arrangements*

There were three organisational models (with various permutations) for public health teams: a separate public health directorate (with the Director of Public Health (DPH) directly accountable to the CE); dispersed arrangements across directorates for public health staff and the public health budget (with accountability of the DPH to a local authority executive director); and a mixed model, where a small senior team was accountable to the CE but operational accountability was through the directorates in which individual public health staff were based. Dispersed arrangements were sometimes associated with public health service delivery agreements with directorates to monitor their use of the public health budget. In most sites, public health support for Clinical Commissioning Groups (CCGs) was described as having reduced.

*Health inequalities*

More emphasis was being placed on groups most likely to suffer from health inequalities over the longer term (such as children identified as not ready for school) and on addressing poor quality of life and reduced life chances for groups including migrants, socially isolated people, people with mental health problems, lone parent families, young offenders and children leaving care. In most sites, there was less emphasis on reducing premature mortality over the shorter term. The responsibility of the local authority as ‘corporate parent’, for example, could take precedence over concern with adult lifestyle choices. There was a shift from universal to targeted approaches, with disquiet expressed by some interviewees over the potential impact on health visiting services. Key to prioritising health inequalities was the interest and commitment of elected members and inclusive consultation, but there was less reference to the evidence base for narrowing the gap. Place-based approaches and an understanding of local context and local networks were important if implementation strategies were to be effective.

*The public health budget*

As a local authority budget, the ring-fenced budget was often aligned to local authority priorities (especially the needs of children and vulnerable adults) and often used to fund local authority services where cuts would have had an impact on health outcomes. Priorities were influenced by the Joint Strategic Needs Assessment (JSNA), elected members and local knowledge. In most sites, HWBs were not a main forum for detailed discussion of the budget. The budget was used in a wide variety of ways, including being ‘rebadged’ under ‘wider determinants of health’, but the extent of this varied as did the degree of control over the budget by the DPH. In some cases, there were integrated approaches to reprocurement across public health and other budgets and pooled arrangements, often linked to the integration agenda. There were examples of the public health budget being used as a catalyst for preventive initiatives in CCGs, as well as across local authority directorates.

In-year cuts to the public health budget were criticised, especially in sites with a low initial allocation and high needs. The ring fence was generally supported (with the important exception of most local authority service/executive directors) but the current selection of mandatory functions was often disputed. With the exception of some sites, non-mandatory services, such as smoking cessation, were at risk and were being reduced. Mandatory services, including sexual health services, were more often protected, but this was less the case for NHS Health Checks.

Scrutiny arrangements were complex, given the cross-cutting nature of public health activities. Levels of scrutiny through health scrutiny committees for public health outcomes and the public health budget varied across sites, from minimal to extensive.

*Commissioning and providing preventive services*

All sites provided lifestyle services, often determined by historical contracts, but preventive services (e.g. smoking cessation) were being reduced in most sites. Integrated health and wellbeing services were being commissioned, sometimes linked into community hubs. There were alignments across public health and local authority priorities (including services for children’s wellbeing and drugs and alcohol services).Local authority priorities for early years’ services were often aligned with established public health priorities, reflected in the Marmot principle to ‘give every child the best start in life’.

Preventive services were being recommissioned and local authority procurement processes had resulted in efficiencies, more detailed outcome-based specifications (including for social outcomes), greater targeting, use of incentives (in a few cases) and a wider range of providers. There was more emphasis on social and community elements of preventive services, peer-based approaches and social prescribing.

There were differences of view over what constituted evidence or cost-effective interventions in a local authority context: members felt they understood the needs of their communities and were elected to reflect community priorities. It was, therefore, important that evidence was locally relevant and implementation was context-sensitive. Short-term electoral cycles influenced priorities, while public health outcomes were longer-term.

*Community engagement and co-design*

There was evidence of more community engagement and involvement of the VCSE sector in developing the JSNA, and some evidence of co-design, particularly in the recommissioning of drugs and alcohol and sexual health services.

Overall, there was greater emphasis on individuals and communities taking responsibility for their own health and on the role of local authorities in encouraging volunteers, building community resilience and developing community assets. This was sometimes discussed in the context of a need to redefine the relationship between the individual and the state, reducing demand on statutory services and encouraging communities to help themselves. This was reflected in authorities under different political control and while it was often linked to the lack of any alternative in the context of austerity, links were also made with the benefits of empowerment and developing community assets.

*Innovation*

The location of public health teams in local authorities had led to synergy across different approaches and was seen as a source of innovation, influencing both traditional preventive services and services provided by local authorities. Engaging with local communities was seen as a *sine qua non* of innovation, as creative solutions came from people and their life experience. In the same way, a focus on localism and views of members, rather than central government direction, fostered local innovation.

Other innovative developments included developing local authority staff (such as the fire service) into a public health workforce, the systematic adoption of ‘Making Every Contact Count’, the creation of referral pathways across, for example, housing officers and health trainers and widespread use of technology (online resources, online counselling, reminders). Some interviewees considered that austerity had ‘forced’ innovation.

*Commissioning across a whole system*

Addressing public health challenges required collaboration across local authority directorates, the NHS and partners across a whole system. However, breadth of membership of the HWB varied, as did its discussion of wider health issues and the VCSE sector was not represented on the HWB in half of the sites.

There was variation in how cross-directorate working was interpreted, implemented and coordinated across sites. Where public health was better integrated into an authority-wide commissioning team, it was argued that the JSNA could help underpin commissioning decisions more widely across directorates and also promote cross-directorate working.While involvement of public health staff in directorates for adult and children’s services was common, there was less evidence of involvement in highways, environmental services planning or regeneration. However, in some sites, ‘acceleration’ of cross-directorate working was described, with influence over local authority strategies and plans which had not been possible previously, even where DsPH were joint appointments of long-standing.

Fragmentation was described in relation to commissioning primary care services, health protection arrangements (in a minority of sites) and data sharing. For multi-district authorities, where responsibilities for housing, leisure, planning and environment rest with district councils, there were questions over links with public health teams, coordination of public health services and how far public health priorities agreed at the HWB, for example, were reflected at a district level.

*Leadership by the public health profession*

Needs assessment, data analysis and modelling skills were highly valued and often integrated within different directorates. In some sites, there were reductions in public health capacity, loss of prestige and status and risk of becoming a ‘local authority officer’. There was less emphasis on a ‘public health commissioning system’ than on a ‘commissioning system with public health included in it’. A commissioning role was less important than the capacity of public health teams to influence across the local authority. This needed political credibility, skills in persuasion, networking across directorates and close working with elected members, which included helping them to develop their public health role. Some local authorities were actively developing a public health workforce and argued for training which was suitable for public health in a new context.

*Public health leadership role of local authorities*

While almost all local authority activities could be described as having a public health impact, there was a spectrum of engagement in a public health agenda across the ten sites, with some sites being highly proactive. This was reflected in cross-directorate working, commitment (and portfolios) of elected members and strategic priorities. ‘Mainstreaming’ the public health agenda was key and while it was common for local authorities to be described as a ‘public health organisation’, there was a wide spectrum of involvement in relevant activities. Interviewees articulated many local public health challenges, but it was often unclear how these challenges could be addressed given the statutory responsibilities of local government.

## Conclusions

The study demonstrated variation in the ways that prevention and public health are being defined, a public health contribution is being interpreted and the reforms are being implemented. It shows how successful alignment of public health skills and approaches with local authority priorities is influenced by the extent to which a public health ethos is already in place and reflected through member support for a public health agenda, organisational arrangements and cross-directorate working.

There was a noticeable mismatch between the main advantages of the reforms in theory (that is, influence on the wider determinants of health) and how public health roles were often described in practice (contribution to data analysis and needs assessment). This was less the case for sites with a long-standing commitment to public health, but the degree of proactive public health engagement across local authority directorates was highly variable.

As almost all local authority activities could be described as having a public health impact, destinations for the public health grant were many and various. In most sites, however, there was an agreed alignment with, and contribution to, other local authority services, such as leisure and the recently integrated children’s services. Different understandings of prevention and public health and of the role of individual responsibility influenced notions of evidence, how the budget was to be spent and also how health inequalities were addressed and identified.

For preventive measures, the key question was ‘prevention of what’? Emphasis could be placed on preventing pressures on various ‘front doors’ of hospitals, social care and children’s care homes. Preventive activities in this context largely focused on needs of the most vulnerable client groups, preventing or delaying the need for statutory services.

Emphasis on individual responsibility (e.g. for smoking), short-term demand management, or on the wider determinants of health could all result in a lack of focus on specific preventive services.

Extent of integration of public health staff (and the public health budget) into local authorities was a key issue. While being part of a stand-alone directorate could provide credibility, location within other directorates could potentially lead to a loss of professional integrity, weaken a sense of identity and the professional skill set, making its separate contribution difficult to identify.

More significant is the extent to which a social perspective is integrated into traditional preventive services, a public health perspective is included in local authority services and political commitment to mainstreaming a public health agenda is demonstrated across local authority directorates. The study showed that while all these aspects could be demonstrated, methods and degrees of implementation varied across the sites.

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 DH 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 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, and further extended until April 2018.

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 from a range of providers; and (3) the 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 an 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.

This report presents findings from first phase fieldwork and is informed by four research reports competed as part of the scoping phase of the study. Previous research reports and further details of the project are available on the project website. [**https://www.dur.ac.uk/public.health/projects/current/cphs/**](https://www.dur.ac.uk/public.health/projects/current/cphs/)

# 2. Methods

This aspect of the research study involves fieldwork across ten case study sites across England. Site selection and recruitment of interviewees are discussed in more detail below.

**2.1 Selection of sites**

As outlined in the research proposal, we planned a sample of ten case study sites, to include at least two multi-district authorities and authorities under different political control. Selection of sites was informed by the scoping phase of the study (see research reports 1-4), advice of the External Advisory Group, and by criteria such as level of disadvantage, rurality, geographical spread, ethnicity and evidence of innovation. We drew up a short-list of sites which fitted our selection criteria and access requests were sent to potential sites over a six month period, starting at the beginning of June 2015. If a site refused, we selected an alternative site which met similar selection criteria. Before reaching the number and types of sites required, we approached 19 sites, with nine refusing to participate due to time pressures.

As shown in Table 1, our sample of ten sites reflected our selection criteria. Each region of England is represented, with the exception of the North East (three sites were approached but refused to participate) and three multi-district authorities are included. Two of the case study sites also formed part of a previous NIHR-funded study on commissioning for health and wellbeing in the NHS, which allows for comparison (Marks et al., 2010).

Table 1: Case study sites

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

**2.2 Recruitment of interviewees**

In order to reflect a broad range of views, we aimed for ten interviews per site, to include the DPH, CE, Service and Executive Directors (Adult Social Services/Children’s Services/People/Communities), a CCG member of the HWB (usually Vice or Co-Chair), HWB Chair, Health Scrutiny Committee Chair, NHSE member of the HWB, Healthwatch Chair and a representative from the VCSE sector. Where the VCSE sector was not represented on the HWB, a representative from a local umbrella body was invited to participate. There were differences in sample size between sites to reflect multi-district authorities (where a district council representative on the HWB was also invited to participate (n=3)) and additional elected member representation on the HWB (n=3). Brief snapshots for each case study site were prepared beforehand to provide a context.

Table 2 summarises recruitment, providing a general indication of roles: actual titles may differ. Out of a total of 107 potential interviewees, 17 declined to participate. Between seven and 12 interviews were carried out per site, with the majority (n=72) carried out face to face and the remainder (n=18) by phone. DsPH, Directors of Adult Services (or a named alternative) and a representative from the VCSE sector participated in each site, while NHSE members of HWBs were the group with the most refusals (n=4). The same ten roles, which included the six statutory HWB members, were reflected across all sites. Due to reconfiguration of management structures into a fewer number of directorates, interviewees in some sites were responsible for both adult and children’s services and, as shown in Table 2, alternatives were sometimes suggested to reflect specific commissioning responsibilities. The VCSE sector was represented on the HWB in five of the case study sites.

All HWBs are chaired by an elected member. Of the eight HWB chairs who agreed to be interviewed, three were either leaders or deputy leaders of the council. HWB chairs held a wide range of portfolios, including the NHS, community engagement, community sector, adult social care, children and families, education and skills community wellbeing and older people. Of the three additional HWB elected members who were interviewed, one had a specific portfolio for public health. In other cases, portfolios covered a combination of adults, children, older people health and wellbeing. We also interviewed eight elected members who were Chairs of the Health Scrutiny Committee. As is usually the case, they were not HWB members. Of the seven CEs interviewed, two were also members of the HWB. Of the seven CCG representatives interviewed, all were HWB members: four were also Vice-Chairs of their HWB and one was a joint chair.

A member of the VCSE sector was interviewed from all ten case study sites: three were employed by national voluntary organisations, but all were involved with networks of VCSE sector organisations at a local level. Of the five HWB members, one acted as the sole representative of the VCSE sector, three shared this responsibility with another representative, and one interviewee was part of a group of four VCSE sector representatives on their local HWB. Where the VCSE sector was not represented on the HWB, a representative from a local umbrella body was invited to participate.

**2.3 Interview schedules**

A generic interview schedule was developed (Appendix A) and modified to reflect interviewee roles and responsibilities. The interview schedules were informed by interviews carried out with national stakeholders, which included DsPH, CCGs, elected members and representatives from the VCSE sector, the Local Government Association (LGA) and Healthwatch England. Interviews explored the following questions:

* Changes in roles and responsibilities;
* Views of the public health reforms;
* How public health services are being funded and changes in how the public health budget is being used over time;
* How preventive services are being commissioned and provided and their impact on health inequalities;
* Innovative approaches to promoting health and narrowing health inequalities;
* How commissioning is taking place across the new public health system;
* How local authorities are developing their leadership role in improving health and addressing health inequalities.

Interviews began in October 2015 and were completed in May 2016 with the bulk (86) completed by early March. Interviews were recorded with the permission of the interviewee and transcribed verbatim by an external transcription agency Fieldwork was carried out by LMJ, Kate Melvin, SV and LM. Analysis of transcripts (using NVivo 10) was carried out by LMJ and transcripts were also separately analysed by LM. Local authorities are very distinctive and varied: anonymity is therefore difficult to achieve. In order to capture contextual detail we also analysed data by site for five research themes. In this report we present an overview in order to preserve anonymity.

Table 2: Recruitment for phase one fieldwork

|  |  |  |
| --- | --- | --- |
|  | **Case study site** |  |
| **Interviewees** | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **Total**  |
| HWB Chair | R | R | R | RT | D | D | RT | R | R | R | **8** |
| DPH | R | R | R | R | R | R | R | R | R | R | **10** |
| CCG (HWB member) | RT | R | D | R | R | R | R | R | D | D | **7** |
| CE | R | R | R | D | R | R | D | R | D | R | **7** |
| Director (Children’s Services) | R | R | R | A | A | A | R | R | D | RT | **9** |
| Director (Adult Services) | R | R | RT | R | (A) | R | RT | (R) | A | (RT) RT | **9** |
| Healthwatch Chair/CE | R | R | D | R | R | A | R | D | RT | A | **8** |
| Health scrutiny committee Chair | R | D | R | RT | R | R | RT | R | R | D | **8** |
| VCSE sector (HWB member) | N/A | N/A | RT | N/A | N/A | R | R | R | R | N/A | **5** |
| VCSE sector (other) | RT | R | N/A | R/T | R | N/A | N/A | N/A | N/A | R | **5** |
| NHSE (HWB member) | RT | D | RT | R | R | R | D | RT | D | D | **6** |
| Elected Member (Additional HWB member) | R | N/A | N/A | N/A | N/A | R | N/A | N/A | N/A | R | **3** |
| District Councillor  (HWB member) | RT | N/A | N/A | N/A | R | N/A | N/A | N/A | R | N/A | **3** |
| Additional Interviewees |  |  |  | RT | RT |  |  |  |  |  | **2** |
| **Total**  | **12** | **8** | **8** | **10** | **10** | **10** | **8** | **9** | **7** | **8** | **90** |

R: Recruited (face to face interview) RT: Recruited (telephone interview)

 D: Declined N/A: Not applicable or post not filled

A: Additional/delegated Bracket signifies multiple responsibilities

‘A’ refers to additional interviewees, whether via delegation or recommendation. A second elected member of the HWB was invited depending on the portfolio held by the HWB Chair.

**2.4 Documentary analysis**

Documentary analysis is ongoing and includes documents suggested by interviewees and relevant documents presented to HWBs and to Health Scrutiny Committees.

**2.5 Follow-up interviews**

A total of 20 follow-up interviews will be carried out across the 10 case study sites at the end of 2016.

The final report will bring together different elements of the study to include a comparative analysis of case study sites.

# 3. Results

Results are presented for the main research themes of the study: the public health budget (3.5); commissioning and providing preventive services (3.6); innovative approaches (3.7); commissioning across a whole system (3.8); and the public health leadership role of local authorities (3.9). This section begins with an analysis of organisational and accountability arrangements and then provides a context for the findings by summarising views of the advantages and disadvantages of the reforms (3.2), approaches to health inequalities (3.3) and the impact of austerity (3.4), which coincided with the transfer of public health responsibilities.

## 3.1 Organisational and accountability arrangements

***3.1.1 Introduction***

The transfer of DsPH and their teams from the NHS to upper-tier and unitary authorities in England has resulted in changes in how public health functions are carried out, in responsibilities of individual DsPH and in accountability arrangements of DsPH and other public health staff. It has also changed the level of public health input to CCGs and therefore public health involvement in healthcare public health and strategies for prevention in primary care. In the former Primary Care Trusts (PCTs), DsPH were executive directors, accountable to the CE with ‘an equal vote’ and able to speak ‘in an equal way at the public board meetings’. They were involved in strategic development across health improvement, health protection and health service improvement. The transfer to local authorities has resulted in a change of emphasis and a wide variety of organisational and accountability arrangements which have implications for public health leadership, deployment of the ring-fenced public health budget and the level of cross-directorate working.

***3.1.2 Organisational models***

Our ten case study sites reflected three main models, although there were numerous permutations: a separate public health directorate; dispersal of public health staff across directorates; and a senior public health team but where operational accountability is to the directorates in which public health staff are based.

The first model was the establishment of public health as a separate directorate of the local authority. In one site, there was a separate public health directorate, headed by the DPH, with responsibility for a wide range of services (e.g. housing-related support, libraries and community engagement)[[1]](#footnote-1). In two further sites, a separate public health directorate was largely focused on public health-related services and in another the focus was on public health intelligence, while commissioning of public health services was the responsibility of an Executive Director. Leisure services could also form part of DPH commissioning responsibilities, given their public health potential, and there was also an example of a public health directorate acting as lead agency for domestic abuse specialist services (funded through the public health grant). One CE expressed the view that a separate directorate reflected the importance of public health and was essential if its credibility was to be maintained:

*So that was something I did very deliberately in the end because I felt that it was important that the function was given that kind of level of reach in the organisation. And my sense is in looking at some organisations that where they bury the directors of public health in the guts of the organisation then the focus is lost a little bit.*

The second and more usual model, involved dispersal of the public health team across local authority directorates. This often included incorporating some public health staff into centralised information and commissioning services (and, in one case, strategic services). This was the direction of travel in a number of sites, even where DsPH currently held commissioning responsibilities. In one site, however, the public health team had a separate performance and commissioning group, which developed strategy related to the public health grant.

There were examples of mixed models, where operational accountability was through the directorates in which individual public health staff members were based but with a small senior team accountable to the CE. Staff were typically based with children’s services, adult social care or community services. Reasons cited for dispersal included promoting relationships, improving cross-directorate working, enabling theme-based work across the authority and achieving ‘more interfaces with more people’.

One CE commented:

*We did not want to see public health tagged on as a department, a specialist department somewhere in the chief executive’s unit. We wanted public health to be completely integrated into the council, influencing every part of the council with a key line of sight to me and elected members. So it has affected that, it’s created opportunity and challenges*.

However, some argued that where public health was constituted as a separate directorate it could be viewed as an ‘outpost’ and could lead to public health responsibilities being seen as resting with the DPH, rather than with the authority as a whole.

Across sites there were numerous examples of public health teams carrying out needs assessments, data analysis, targeted strategies for particular groups across directorates and providing services in different locations (such as youth centres and libraries).

***3.1.3 Accountability and reporting arrangements***

A separate public health directorate implied formal accountability to the CE (as was the case in five sites). The second model was accountability of the DPH to a Service or Executive Director, although titles and roles of directors varied by site, reflecting different organisational arrangements which obtain in local authorities (e.g. Directors of Adult Social Care, Children’s Services, Communities, People). However, formal accountability of this kind did not preclude membership of corporate management teams nor of various executive and senior partnership committees and DsPH were often members of senior management teams. Given there were often very few directorates, each with a large number of responsibilities, such accountability arrangements were viewed as inevitable by many local authority interviewees, although often described as not welcomed by DsPH.

Of more significance was accountability to elected members (DsPH could report to more than one member depending on their responsibilities) and, in particular, the portfolio holder with responsibility for public health. As described in section 3.9, this meant DsPH had less autonomy over decision-making than they had experienced in the former PCTs.

A DPH described the focus on:

 *briefing the councillors with the responsibility for public health because the decision- making process is different and at official council meetings it is the councillors who speak and not the officers. That is the way that local democracy works.*

There was, however, less central direction than in the NHS ‘so the ability as DPH to work with the councillors to shape how the function works is greater’.

DsPH and their teams worked alongside cabinet leads, HWBs and Scrutiny Committees, although the extent to which the latter took an active interest in scrutinising public health outcomes was variable. For cabinet leads, portfolio allocation could be influential as Members who chaired HWBs could encompass various responsibilities, singly or in combination (for example, children’s services, adult services, social care, community wellbeing and public health). In some sites, they also held the position of Leader/Deputy Leader of the local authority, which added to the influence of the HWB. While the view was expressed that a mix of portfolios enabled connections to be made across local authority functions, others considered that a cabinet member focused on public health served to strengthen and provide a focus for this agenda. An Executive Director noted that:

*We've designated a public health champion on the cabinet. We haven’t just given it to the adult social care cabinet member. So we have a designated public health champion. The health and wellbeing of the city is now one of our main priorities, which it wasn't before*.

Interviewees also raised issues related to HWBs, their breadth of membership and their influence on a public health agenda. However, the HWB was one of many arenas for discussion, with decisions often made in separate corporate management or joint commissioning committees. In some sites, children’s partnership boards had been retained which meant that children’s issues, such as child obesity, were not discussed in detail at the HWB. HWBs were described as ‘confusing’ in a local authority decision-making context and their role in influencing rather than in decision-making or scrutiny was described as ‘difficult to unpick’. However, even within the same site, interviewees held different views of their HWBs, with some identifying improved partnership working, partly fuelled by the Better Care Fund. (The leadership role of HWBs is the subject of a separate DH PRP-funded research project.[[2]](#footnote-2))

***3.1.4 Public health support for CCGs***

One of the mandatory elements of the transfer, and reflected in the reporting categories of the ring-fenced public health budget, is the requirement on the public health team to support CCGs, in areas such as prevention, detection of early cancers, screening and immunisation programmes, interpretation of data, health needs assessments priority-setting and programmes for long-term conditions. There was often a memorandum of understanding in place, although the importance, or relevance, of this was sometimes questioned. One CCG interviewee commented:

*You also hear in surrounding areas an inordinate amount of time being spent between the CCG and public health on creating memorandums of understanding about what each other will do. Inordinate amounts of time, including legal expense. So that doesn’t happen in {name of site} and I think that comes from the time we’ve had together. We just wouldn’t do that; it’s just culturally not what we’d do. We’d come to an agreement and we’d never get a document out and approve it. Whereas other areas because they don’t have the relationship they need that assurance.*

In the majority of sites, DsPH were formal (usually non-voting) members of CCG governing bodies. Public health consultants could be allocated to each CCG, while still retaining responsibility for public health-related themes across a wider area; CCGs could work with a range of public health consultants; or, as in one of the sites, members of the public health team could simply provide advice when asked. However, in most sites, interviewees saw this support as having decreased since the transfer of public health teams to the local authority and some CCG interviewees expressed concern over a reduced focus on prevention in primary care. Reductions in public health staffing levels also meant there was less time to engage with CCG priorities. In contrast, in one site, the importance of a continuing and substantial public health role in CCGs was particularly emphasised, as was the benefit of influence over the whole of the CCG budget (rather than over the relatively small public health budget). This illustrated the use of the public health budget as a catalyst, further discussed in section 3.5.6.

However, some frustrations were expressed over this element of the changes, described by one DPH as follows:

*I’ve specialised within commissioning healthcare, so my role essentially was taken out of the NHS as a strategic planner, understanding population need and value and evidence base and reducing health inequalities, moved into local government and then deployed from local government back into the NHS, but without being employed by the NHS, so it’s a really strange set-up and we’re managing to be as effective as possible within, frankly, quite a crazy system.*

A history of effective partnership working across the local authority and the former PCTs, along with joint DPH appointments, was key to developing good working relationships and what was described as a ‘seamless transfer’ in some sites. In two sites, there had been integration of health and social care prior to the reforms and a tradition of cooperation.

In summary**,** this section illustrates how roles and responsibilities of public health teams have been operationalised across the CCG and local authorities across our ten sites and how interviewees viewed separate and dispersed models. It indicates the complex relationships that were emerging across professional, managerial and democratic accountability, issues which are explored in further detail under thematic areas of the interview schedule that reflect the original study objectives.

## 3.2 Advantages and disadvantages of the public health reforms

***3.2.1 Introduction***

Since the public health reforms were implemented, in April 2013, there has been debate over their impact on the public health profession, the extent to which local authorities are fulfilling their public health leadership role and the effects of different decision-making contexts on priority-setting for public health interventions. Research carried out as part of the scoping phase identified many advantages and some disadvantages of the reforms. The greatest disadvantage was the confluence of austerity with the transfer of public health responsibilities, making it difficult to separate the potential impact of the reforms from the actual impact of austerity.

Case study interviewees reflected different perspectives, discussed in more detail throughout this report, to include the extent to which potential advantages were realised in practice.

***3.2.2 Advantages of the reforms***

Interviewees cited many more advantages than disadvantages arising from the public health reforms and many considered there were no disadvantages. The advantage most often mentioned was the opportunity for increased influence over, and involvement with, areas such as planning, licensing, education environment, employment, regulation and housing and, therefore, with wider determinants of health. The community leadership, democratic mandate and place-shaping role of local authorities across all sectors meant that public health teams could shift from seeing health as part of a health economy to a place-based approach to health, helping to ‘shape the place as well as the communities that it’s serving’ (Executive Director). The reforms had already led to closer relationships with planning, economic development and wider determinants in some sites and, in one site, the contribution of the public health team to the social determinants of health agenda was highlighted by all interviewees. The potential for public health staff to work across whole systems, influencing a wide range of plans and strategies was, therefore, enhanced and cross-directorate working had been ‘accelerated’. One CE described this as follows:

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

The reforms were considered by one DPH to have supported a ‘radical shift’ away from commissioning particular lifestyle services to a ‘whole system’ approach, changing the ‘choice architecture’. This was contrasted with the situation in the NHS, which was seen as more centralised and where some interviewees considered that public health had ‘lost its way’, focusing on downstream services and healthcare. A VCSE sector interviewee highlighted the difference of approach:

*Work that my team were doing was... in the poorest areas of the city... and the other was they were working on poverty, capacity building and the development of local partnerships and networks. ... And I was asked to rewrite my team's objectives to demonstrate what they were contributing to the cancer targets for the PCT, because that was one of the PCT's priorities, and I said they can't...... ‘But why are you doing work on debt and loan sharks in this area of the city? What's that got to do with health?’ Which I think is a really extraordinary question, but it was one that we were asked repeatedly.*

The irony of the subsequent emphasis of the NHS on prevention, as reflected in the NHS Five Year Forward View (5YFV) was not lost on interviewees. A DPH commented:

*It seems ironic that now we’ve moved, when we see the new different chief executive of the NHS how much more public health focused the NHS is with the Five Year Forward View, the new planning guidance. So it does seem ironic how the NHS is now much more aware of the importance of public health, the importance of prevention, but it’s happened after public health has transferred to the council.*

A further advantage was the connection to elected members and, therefore, to local communities and community networks. In some sites, too, the local VCSE sector described closer working relationships with public health teams (although in other sites this was not the case). Capacity-building and developing local engagement and networks were seen as fundamental for health, although there was greater involvement with local authority neighbourhood teams in some sites than in others. Where community development work had been prioritised by public health teams in PCTs, relocation had reduced duplication and allowed for joined up commissioning with the voluntary sector, using pooled resources.

Integration of children’s services, following the original transfer of school nursing services in April 2013 and, in particular, since the transfer of health visiting services in October 2015, was welcomed. All ‘pieces of the puzzle’ for children’s services were described as in place, including children’s centres, health visiting and school nursing. Health visitors could provide services in children’s centres, for example, and public health staff could be involved in commissioning early intervention services and child and adolescent mental health services. They could also work with children’s directorates to ensure the delivery of public health services. In one site, a service director described this as follows:

*We’ve had a programme of work and are midway through a programme of work around a nought to five integrated workforce for young children. So that’s one example of work that’s fairly new and underway in terms of that real amalgamation into the prevention agenda for the under-fives. So that’s good*.

The reforms had accelerated these developments through, for example, making it easier to reshape services by separating out the elements of larger block contracts with the NHS when services were recommissioned. There were already examples of children’s services and health visitors working to a single specification (with combined performance dashboards), but it was noted by some interviewees that close working across public health and children’s directorates, for example, had not been the case previously and that the reforms had therefore made a difference, not least in relation to the quality of information and data. Proximity of senior managers and ‘who you rub shoulders with’ were considered important for developing such relationships. Underlying many of the benefits were closer relationships, which previous joint arrangements had not quite delivered. One DPH noted:

*And I think there's always been a good working relationship between the council and the NHS in {name of site}, but no matter how good those relationships are, when the individuals come from two separate organisations, rather than from within the same organisation, there is a limit on how much can be achieved and on what success can be obtained, really. It is so much easier to develop relationships, maintain those relationships and have productive relationships with good outcomes if the work is done from within the same organisation.*

This was reiterated by a VCSE sector interviewee who commented:

S*ince they went back into the council, I mean I see ever such a lot of them {public health} really. And that means sometimes you can get things fixed in the corridor and not at the health and wellbeing board…. just by having a conversation with somebody that can make a difference ... So I think that’s been really helpful****.***

The focus on children’s services served to align local authority priorities for early years’ services and early intervention with established public health priorities, reflected in the Marmot principle to ‘give every child the best start in life’. Some authorities had adopted a lifecourse approach across their strategic priorities. The ‘early help’ agenda and early years’ services were stated as key priorities for local authorities and public health teams were often closely involved. For example, in one site there was a public health post within a care leavers’ team to improve care outcomes.

Related to the above was involvement in integration initiatives and in collaboration for health, social care and ‘wellbeing’, although ‘wellbeing’ in this context often referred to prevention of hospital admission or early discharge for vulnerable groups. Providing community support, often through volunteers and in collaboration with voluntary organisations, was seen as crucial for managing flow through the ‘front door’ of social care. In some authorities, public health was seen as playing a key role in these areas, as summarised by a service director:

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

Local authority interviewees often highlighted the benefits of public health teams in terms of their data skills, knowledge of the evidence base, help in targeting services, and bringing a ‘new way of thinking, in a rigorous way’. Other directorates had been encouraged to ‘own’ the JSNA, for example, including issues such as child sexual exploitation and the needs of children in care. An Executive Director noted:

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

The benefits of bringing ‘academic research thinking into a more localised place’ were also cited. A director noted:

 *Their professional background is in analysis and research. Obviously most of my people's officers are much more operationally focused. So it's equally important to bring together that academia, if you like, along with more on the ground practice. Your intelligence from on the ground, it gives a richer source of information.*

There were also examples of public health teams providing research skills in directorates where these had been cut back. Some interviewees also highlighted the contribution of public health teams in debates about the impact on public health of cuts to services.

Finally, stronger procurement skills in local authorities were also cited as an advantage of the reforms, leading to improvements as services were recommissioned (see section 3.6.2). A DPH noted:

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

In the same site, recommissioning drugs and alcohol services had led to greater emphasis on the impact on children and on their wellbeing and on domestic violence, thus linking across the authority’s priorities.

Most VCSE sector interviewees viewed the public health reforms positively, including their impact on the VCSE sector. Interviewees spoke of wider stakeholder engagement, increased co-production and the profile of the sector and of partnerships being raised, allowing the public so see ‘what we’re doing locally is done collaboratively’. One interviewee who was a member of their HWB and another who was not, shared a view that public health was more visible within local government as well as being more open to engaging with the VCSE sector. One described how public health staff would now ‘come to us and say “we think this is a need, is there something you would think about offering?”

Some interviewees described a balance across advantages and disadvantages and, in two sites in particular, views were mixed. For example, while location in a local authority meant that public health staff could more easily criticise national policy, the same did not apply to policies espoused by the local governing party. The notion of HWBs was welcomed, but there was often criticism of how they worked in practice or how well they fitted into local authority decision-making processes. As discussed in section 3.5, the ring-fenced budget was seen as protective by many, especially over the shorter term, but also criticised for its lack of flexibility.

***3.2.3 Disadvantages of the reforms***

Main disadvantages were the concurrent impact of austerity, the potential effects on the public health profession, an increased emphasis on short-term outcomes and a degree of fragmentation in commissioning preventive services.

As mentioned above, austerity was described as ‘derailing’ the reforms, especially in inner city areas: local authorities were seen as a ‘high risk’ environment for public health, given continuing cuts in their overall budgets; and the public health budget could easily be reframed in line with local authority priorities and statutory commitments. Public health funding was considered more likely to be squeezed ‘disproportionately’ than in the NHS, which had more financial protection, hence concerns about the end of a ring fence, however permeable. Concerns were also expressed over a potential loss of substantial NHS investment in health visitors prior to transfer and over a change from universal services and national standards to more locally agreed and targeted services (as had already been the case in some sites, following transfer of school nursing services). An NHSE interviewee commented:

*In NHS England there was a huge programme of work to improve health visitor numbers and commission services in a certain way. And now it’s going over to local authorities. Quite understandably they’re doing their things locally or procuring, and you’ve lost any of that grip of numbers and improvements on a national level. And I think it just gets very muddy around whether it’s locally based or you want some consistency of standards across the board.*

There was concern that the NHS investment would be ‘stripped out due to austerity measures’ after the initial period, and that changes were not being ‘adequately scrutinised’.

Interviewees also commented on actual and potential effects on the public health profession, its role and sustainability (a point returned to in the discussion section). First of all, the process of transition was described as a ‘culture shock’ for public health professionals (and sometimes for local authority service directors, too). The prestige attached to the profession had been dented, according to some interviewees, partly because of changes in accountability arrangements (as mentioned in section 3.1) and partly as a result of the lack of acknowledgement of a consultant role within a local authority context. One DPH argued that ‘local authorities are still not keen to have consultants with consultant grade’ and some consultants had recently been employed under a local authority contract, rather than a consultant contract. A CCG interviewee noted that ‘most of the public health staff I’ve come across **...** were not very happy in the transfers and the way it was done, and the changing roles and responsibilities that they felt they had’.

The capacity of public health teams had been reduced, sometimes dramatically, described in one site as a ‘closed shop with dwindling members’ and there had been disruption in two sites due to a succession of interim DPH appointments. With a few exceptions, there was less involvement or interaction with primary care and with the NHS in general. This meant that capacity to work with CCGs on healthcare public health or influence their strategic decision-making had diminished in most sites. Transfer could also include challenges in engaging with a broader health and wellbeing agenda, rather than the narrower focus of the NHS. In a few sites, public health was seen as a ‘bit of a bubble’, while in others it was largely integrated. There were comments in a number of sites over cultural differences. In one site, public health staff were described as follows:

*I* *think public health practitioners tend to be reflective people who produce a lot of reports. Politicians are often people that want to see things changing immediately, short-term stuff. So I think culturally there are those difficulties.*

In another site, similar views were expressed by a local authority assistant director:

*I think the mindset if you like of public health professionals is a health service mindset which is very different from the local authority. It’s much less outcome focused, it’s much less self-critical, and it’s much less driven by notions of financial accountability within finite timescales. ...they are two completely separate worlds.*

In terms of professional development, some public health interviewees cited less sharing of good practice, a decline in regional or sub-regional involvement and more professional isolation. One interviewee, for example, saw little future for the profession, considered that senior strategic roles had been degraded to middle grade management roles, reported that many public health staff had left or taken early retirement and that it would no longer be seen as an attractive career option for junior doctors. One consultant expressed this as follows:

*I cannot believe it is sustainable and for me that’s why I’ve already started to exit from public health, because I don’t see a future for myself in it.*

Others commented on the loss of talent from the profession and the future of the profession in its current form was questioned by a senior manager:

*I think the other disadvantage is that over time it's quite likely that public health practitioners will become local authority officers and you'll lose the clinical governance* *and the clinical input, potentially. I think that will happen.*

In another site, the DPH commented on the terms and conditions of transfer and effects on recruitment:

*There are these issues coming into the system about, ‘I don’t want to lose my continuity of service; I don't want to lose my big redundancy payment; I don’t want to go onto local authority conditions when I'm at a stage in my career where I've built up quite a lot through other NHS terms and conditions’ - that is actually a real problem nationally, I think.*

One DPH took a more sanguine view of this issue, seeing potential in the development of a new public health workforce in a local authority context.

‘Politicisation’ of a public health agenda, ‘electoral timescales’ and an emphasis on short-term outcomes were seen as further potential disadvantages. A Chair of a Health Scrutiny Committee reinforced the importance of short-term results in a local authority context:

*Most local authorities, because it’s political as well, want instant answers and instant results. So if you have a link road for instance and the traffic suddenly disappears from that village you’ve got an instant result.*

A number of DsPH expressed frustration over a lack of response by members to the evidence base on particular issues and concerns were expressed by several CCG interviewees over the difficulties of getting health professionals to ‘trust members and a political system’. Where there were frequent changes in elected members as a result of local elections, the resulting lack of continuity (in commitment, in committee membership and in priorities) could slow progress of the reforms.

However, there was also recognition that decision-making was not simply a technocratic matter, but a function of values expressed through democracy. A DPH argued that:

*you’ve not just got a scientific and technical rationality about where it’s most important to invest the money to improve health and wellbeing, but in the decision- making about where you invest, that is still important, but you’re also valuing public preference expressed through the political representation in that place*.

Fragmentation was highlighted by a number of interviewees, given the separation of functions across CCGs, NHSE and the local authority in areas related to health protection and immunisation and vaccination (see section 3.8.4). It was questioned, for example, how serious incidents were being defined in the new system. Some CCG interviewees considered that the reforms had weakened prevention in primary care and that a better balance was needed locally across action on wider determinants of health and prevention in primary care. A CCG interviewee commented:

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

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

Interviewees from the VCSE sector also spoke of disadvantages. Some were associated with the unavoidable process of transition, including damage to relationships due to people changing role or leaving public health altogether. For two-tier sites, VCSE sector interviewees also experienced disadvantages arising from the ‘disconnect’ between county council and district councils, which could affect priority-setting and commissioning decisions. Whilst some VCSE sector interviewees found the new commissioning arrangements supported VCSE engagement at the design or invitation to tender stage, and supported small-grant funding for pilot projects, others found local authority procurement processes ‘labyrinthine’. One interviewee commented that:

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

Others spoke of contract specifications which excluded small providers, leading to these organisations losing their core funding and effectively being left ‘high and dry’. There were examples of organisations losing public health funding but securing resources from alternative sources, such as the Big Lottery Fund, but most interviewees were concerned that continued austerity measures would be damaging to the VCSE sector in the long term. Some interviewees also voiced concern that decision-making would be influenced by elected members’ preference rather than ‘evidence based best practice’.

Overall, response to the reforms was positive. However, some argued that many changes predated the reforms, described as a continuation rather than as a transition, although the Health and Social Care Act was considered to have ‘crystallised’ views. A concern with population wellbeing was already intrinsic to the role of a local authority and one interviewee noted, for example, that ‘health and wellbeing’ was the wrong way round as wellbeing was not just a product of good health but of a healthy social and economic environment. In some authorities, commitment to public health, support of members and long-standing partnerships (for example, for children’s services) long predated the reforms and in one site, key changes (such as reorganisation along Marmot principles) had already been made. Nevertheless, some interviewees described greater involvement with planning and enforcement, even where there had been strong partnerships beforehand.

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## 3.3 Approaches to health inequalities

***3.3.1 Introduction***

New local authority responsibilities for improving health and addressing health inequalities were reflected in conditions for the use of the public health grant as well as through the overarching indicators for the Public Health Outcomes Framework (PHOF). Influencing social determinants of health and health inequalities implies combinations of cross-directorate working; the health (and health inequalities) impact assessment of policies and plans; and building public health concerns into the routine working of directorates. As outlined in section 2, case study sites were purposively sampled to reflect a range of sites from the most to the least disadvantaged, as measured by the Index of Multiple Deprivation. However, all sites had areas of deprivation and, in some cases, there were marked contrasts between extremely affluent and highly deprived areas, including coastal areas. Inequalities in access figured prominently in rural areas, and were sometimes described as the main concern in relation to the health inequalities agenda.

This section focuses on how health inequalities are being conceptualised across local authorities and CCGs since the reforms, compares approaches with those adopted by the former PCTs and explores the impact on local practice.

***3.3.2 A shift of emphasis in the health inequalities agenda***

Some of the case study sites had long-standing commitments to addressing health inequalities, reflected in local authority plans, partnerships or joint programmes with the former PCTs, and through the former Local Strategic Partnerships. Some local authorities described themselves as already a ‘public health organisation’ or ‘early intervention council’ and where this was the case, it was argued that the reforms provided a continuity of approach.

In the NHS, health inequalities had received a high profile, reflected in national health inequalities targets for narrowing the health gap (2002-10) and in a range of monitoring and performance management arrangements. PCTs were also provided with peer support to help meet their targets for health inequalities but, as one interviewee noted, such support was less in evidence in a local authority context.

A commitment to addressing health inequalities in the local authority helped smooth the process of transition for the incoming public health team. One DPH described this as follows:

*I found this council being extremely receptive to public health coming in to the council: a real understanding by leading councillors about health inequalities. A real desire to improve health and wellbeing, and reduce those health inequalities … . I don’t think we could have had a more welcome, a more welcoming approach really from the council to both myself and the public health staff. We were really welcomed*.

While there was a degree of consistency in the NHS over how health inequalities targets were to be met, interviewees reflected a broader range of approaches. These included an emphasis on vulnerable children and the role of the local authority as ‘corporate parent’; the shift from universal to targeted approaches; an emphasis on ‘consultative’ rather than on ‘analytic’ approaches; a reframing towards priority groups; and cross-directorate approaches. These are discussed in turn.

*Early intervention*

Reflecting social determinants of health and health inequalities and also consistent with the wider role of the local authority in caring for vulnerable children, was an emphasis on early years, as reflected in the first policy priority of the Marmot Review (2010), ‘to give every child a good start in life’. The ‘school readiness indicator’ (at age 5) was emphasised in some sites as a predictor of future inequalities in health and life chances and was, therefore, a key focus for public health investment, especially where numbers not achieving school readiness were high. This could be channelled through a range of ‘early help’ initiatives, including children’s centres. The importance for future health of early childhood development made this a key focus for public health input as well as for public health funding, where services were at risk from cuts.

*Targeting*

Identifying and reaching under-served groups is fundamental to addressing health inequalities. However, financial stringency had led to greater targeting and a move away from universal services, which was evident in all sites. This was reflected, for example, in more targeted (and integrated) approaches to children and to troubled families, in relation to specific services (such as smoking cessation) or to lifestyle services more generally. Interviewees referred to local debates over definitions of prevention and of health inequalities and the balance to be achieved across universal services, self-referral and targeted services. In one site, an Executive Director explained:

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

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

However, in some sites, criticism was expressed by CCG interviewees over the movement towards more targeted approaches in prevention. Some NHSE interviewees were also concerned that the health visiting services transferred to local authorities in October 2015 could, over time, be replaced by a targeted service.

*Consultative approaches to evidence*

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

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

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

*Refocusing on priority groups*

Interviewees often discussed health inequalities in the context of the needs of migrants, socially isolated people, lone parent families and other vulnerable groups, such as children leaving care. One Executive Director commented on the social isolation experienced by children leaving care:

*And unless a support worker or somebody calls in they might go a whole week and not see anybody - which is a not nice thing to think about for a 17 or 18 year old. Well they’ve no family that’s why they’re in care or no family that’s suitable and then you start seeing they’re isolated. So the drug user down the road clocks that they’re isolated, they knock on the door – very soon they’re into a negative cycle*.... .

In these examples, health inequalities were framed less in terms of narrowing the gap in life expectancy and more in terms of poor life quality due to factors such as mental ill health and social isolation. Reflecting their remit to articulate views of seldom heard groups, there were a number of related initiatives cited by local Healthwatch interviewees, including working with refugees and asylum seekers, addressing problems of access to dental services of people with HIV/AIDS and having ‘contact’ events in disadvantaged communities. One interviewee noted that insight work was being carried out with ‘a couple of our hard to reach communities looking at homelessness, sex workers, for example, and going out and actually having those focus group discussions with them’.

In some sites, the emphasis on premature mortality and lifestyle services, predominant in the NHS, was still prominent: in one site, for example, inequalities between different parts of the local authority were being conceptualised in terms of premature mortality with efforts to tackle obesity and smoking - adopting a personalised approach along with an emphasis on a healthy environment.

*Cross-directorate approaches*

Aspirations for integrating a public health approach across local authority directorates are further discussed in section 3.8.2. Issues such as domestic violence or social isolation could be adopted as cross-cutting themes across a council, encouraging cross-directorate working for vulnerable groups. Links were made between the health inequalities agenda, improved housing and economic and regeneration initiatives. In one site, efforts had focused on employment and regeneration programmes for poorer areas, initially through education-based regeneration programmes, but extended to include improved facilities (including play facilities) with the aim of promoting wellbeing and to ‘give people a pride in where they live’. The HWB Chair noted:

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

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

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

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

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

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

***3.3.3 Elected members and community leadership***

Key to prioritising health inequalities was the interest and commitment of elected members in the public health agenda. There was evidence of a political dimension in the way that health inequalities were discussed and prioritised, especially where re-election of members might not depend on votes from poorer areas. Authorities with a large elderly population could also focus less on other groups. In a rural multi-district authority, it was noted that:

*when you look at the numbers and you look at what’s eating up the budget, it is predominantly an elderly population. Now that in itself is a truism. The reality is if you are not careful it can then skew some of your upstream stuff around other sections of the population.*

However, in some sites, there was a strong commitment to addressing health inequalities at member level, as reflected in the following comment:

*I see it as my role as portfolio holder to bang the desk not just for public health and public health activity and services, but to, whenever colleagues are doing anything to say ‘OK well how are we considering health inequalities in this? How are we considering integration opportunities?’ All that. That it’s something we just keep, you just keep hammering away at until it becomes the norm.*

In line with the community leadership role of local government, there was greater emphasis on localities, locality commissioning and on local ‘health and wellbeing hubs’, sometimes as a result of broader neighbourhood networks developed as part of the integration agenda. Across many of the sites, there was an emphasis on individuals and communities taking responsibility for their own health and on encouraging volunteers and community resilience. This did not vary by political control, although the emphasis accorded to supporting community initiatives through funding of community groups or infrastructure organisations did vary across sites. Where the emphasis was on individual responsibility, investment was less likely.

Some interviewees considered progress on health inequalities was unlikely without community-based approaches and community engagement: whether interventions were effective partly depended on understanding the local context and potential linkages. An Executive Director noted:

*And then also if you understand the place better it helps you understand what would have more impact in an intervention, and how you could start to shape and influence that across the whole systems that are involved in that place. So I think it does have benefit much more than being in something that’s slightly separate from that sense of place.*

While a place-based approach was considered important, it was not without its tensions. For example, one authority had strategic priorities with equity of outcome agreed across the city as a whole, but for CCGs there was more emphasis on reflecting the diversity of their populations.

***3.3.4 Views of the VCSE sector***

VSCE sector views on changes in approaches to tackling health inequalities varied, and often reflected the views of other interviewees from within the same sites. Some authorities were praised by VCSE sector interviewees for an extensive engagement strategy, which helped ensure that vulnerable groups were represented: in other sites, the VCSE sector considered they had exerted little influence. Some described Joint Health and Wellbeing Strategies (JHWS) with a strong strategic focus, where the JSNA and JHWS were ‘practically interchangeable’, where the service delivery approach was multi-agency and shared community-based sites, and where links between poverty and mental health or childhood opportunities were recognised and embraced by all partner agencies. Other interviewees were less confident of what was being achieved. One commented that it was difficult to ‘put your finger on if things have improved’, whilst another felt that greater importance was giving to ‘divvying up the cake’ than reducing health inequalities.

In summary, while approaches to health inequalities reflect approaches common in the NHS, there is more emphasis on the needs of vulnerable groups, the role of communities, and on targeting what were previously universal services. While the role of social determinants in health is recognised, its translation into cross-directorate working is less widespread, as is assessment of impact on health inequalities across directorates. Seeing health inequalities as a challenge across the local authority and for the whole community was considered to demonstrate public health leadership, further discussed in section 3.9.

## 3.4 The impact of austerity

Local authority interviewees described the pressures of rising demands, statutory requirements (including new legal requirements arising from the 2014 Care Act) and reductions in budgets, although not all sites were equally affected, due to factors such as revenue from business rates. Authorities were described as a ‘shrinking agency’ and in ‘survival mode’. Cuts across directorates would have repercussions on health and on health inequalities and while the public health budget had been used in some authorities to mitigate effects on children’s services and social care, the budget was described as ‘insignificant’ given the level of cuts across all mainstream services. There were concerns over local authorities being increasingly funded through business rates and the extent to which this could jeopardise much of the public health function: effects would be far reaching in authorities where revenue from business rates were low but demand for services was high. Current reductions in both public health staffing and public health services meant that difficult decisions were being made over the balance across core staff and services and how the best value for the budget was to be achieved. Public health was described as less of a priority in the light of immediate demands on local authorities:

*Public health activities are not as much of a priority when, you know, it’s a bit like saying to a person who’s about to starve to death, well, don’t worry in a few months we might be able to come up with something really rather nice for you.*

Interviewees expressed different ways of responding to the common challenges of austerity - from ‘salami slicing’ to using the total resource of the authority to encourage return on investment and manage demand for social care. This was described in one site as involving ‘a different relationship between the council and the community’ and developing community assets and community development as part of a public service reform programme. In this site, interviewees reported that this approach had enabled closure of a number of day centres and ‘millions of pounds taken out of the social care budget’. Another site reported that transformation of services over the previous five years had resulted in a sound financial position.

There was recognition, too, that the reduction in resources had forced some changes that could be beneficial, in particular, the integration of health and social care which, it was argued, could produce better outcomes for less money.

An elected member noted:

*Yeah, I think it feels to me like trying to find good news really, and it would be misleading for the Department {of Health} to come away and think ‘oh actually yeah, we’re getting more from less, because we release people from the yoke of excessive spending’, which is not true. It would be equally untrue to pretend that ... it hasn’t been a good opportunity to do things better.*

As well as a source of innovation, austerity had led to a greater emphasis on effectiveness, targeting of services, commercialisation of services provided by the local authority (such as healthy school meals) and streamlining (for example, through ‘lateral linkages’, bringing together different data systems around licensing, which had led to substantial savings), whole systems thinking and moving away from what some interviewees described as ‘dependency’ towards a greater emphasis on community resilience. One interviewee clarified the connection:

*We knew our social care budgets were going to get stretched and stretched and stretched, so that we have to close day centres, we’d have to think differently about how we could support vulnerable people in communities. So we forged this new relationship ... and we have a series, network of community hubs*.

In another site, it was argued by an executive director that austerity had led to the public health budget being used to support communities to improve public health outcomes, so that a **‘**resource that could have been being spent on a contract with an NHS provider, may now be spent on developing a community opportunity to deliver the same public health outcomes’**.**

Others were more forthright in their critique of ways in which authorities were shielding the realities of austerity and one DPH spoke of a ‘conspiracy of sufficiency’ to describe the situation where:

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

The roles and responsibilities of public health staff in local authorities are, therefore, not only affected by austerity but also by the responses adopted to austerity in the context of public health priorities.

## 3.5 The public health budget

***3.5.1 Introduction***

One of the three workstreams of the study involves changes in the deployment of the ring-fenced public health budget, transferred from the NHS to local authorities from April 2013. The Treasury announced in June 2015 that the 2015/16 public health budget would be reduced by £200 million (i.e. 7% of the £2.8 billion 2015/16 budget) and this was implemented in November 2015, with each authority’s grant reduced by an equal percentage.

We analysed stakeholder views on key aspects of the budget and its deployment over time to include: how and where the budget was discussed and scrutinised; factors influencing change; pooling arrangements; cross-directorate use of the budget; advantages or disadvantages of maintaining the ring fence; and the distinction between mandatory and non-mandatory services. Separate analyses by case study site of deployment of the budget across all the reporting categories in relation to outcomes were prepared in advance, in order to inform fieldwork.

***3.5.2 Changes in the public health budget***

Sites which had started from a relatively low level of public health funding, as reflected in previous public health spend by the former PCTs, had benefited from an increase in the public health budget since the reforms. However, all sites were impacted by reductions in the budget, notably the unexpected in-year cuts to the public health budget, which were viewed as disruptive and damaging, given contractual responsibilities. Delays in confirming allocations were also criticised. An elected member commented that:

*And similarly we didn’t find out what our allocation was going to be until about three weeks ago for this year that started April 1st. …. when 85% of your money is in contracts* *it’s an impossible way to deal with your providers*.

Changes in the target allocation formula for the public health budget for 2016/17 meant that funding for some sites had been reduced and a CE noted that ‘it clearly directs resources away from greatest need, which is almost perverse in terms of the central thrust of public health investment to target inequality, you know?’

This was echoed by an elected member in a different site*:*

*Big cities and London boroughs that happen to be the poorest communities already, happen to have the hardest stats outcomes, then if you hit them more, if you hit them the hardest with budget reductions then of course ... the ability to close those gaps goes away. And actually what you might see is that the gaps could start to widen. But that seems to be the reality of the situation.*

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

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

In this case, the local authority had compensated for the cut to the public health budget by drawing on local authority funding from other sources, ‘because they can absolutely see those needs’. Similar action was taken in another authority where the allocation was below target and where the impact of in-year cuts was considered unacceptable.

Reductions were most marked for those areas which had benefited from high levels of spending on preventive services by the former PCTs. The point was raised that government cuts to local authorities, combined with the in-year cuts to the budget, had ‘done more damage to the budget than local government would have ever dreamed of’,although damage was less where the public health budget still had reserves to draw on.

***3.5.3 How the budget is discussed and scrutinised***

Discussion of the public health budget followed usual local authority procedures for budget agreement and scrutiny. Scrutiny was achieved through the chairing role of elected members on specific committees, through the range of scrutiny committees, through regular financial monitoring arrangements, and through the Cabinet and the full council. The public health budget would, therefore, form part of these formal reporting arrangements. There were examples of interest in the public health budget, particularly in the early transition phase and, in one site, the public health budget was cited as being included as a separate item as part of monthly financial monitoring (held in public).

Returns for the 18 reporting categories of the public health budget would be processed through the finance department although one interviewee noted that for some reporting categories, such as health protection, the input was difficult to describe or cost. A further complexity was that reporting categories did not reflect the balance of public health-related spend across the authority, although some categories, such as smoking cessation, were relatively straightforward. There was little information available from interviewees on the ‘Miscellaneous’ reporting category, although one interviewee thought it reflected spend on wider determinants of health and another that it had been dispensed with in that authority, as all spending was subsumed under other categories.

There was little detailed knowledge of the budget among HWB members other than the DPH, with HWB discussions described as largely focused on strategic direction or particular proposals for commissioning (or, more commonly, decommissioning). A HWB Chair noted:

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

The public health budget was primarily viewed as a local authority budget. In most sites, detailed discussion took place in executive groups and proposals were presented to the HWB for approval. This was not considered surprising by most interviewees, and was consistent with views that HWBs were not decision-making bodies, did not fit neatly into a local authority structure, were often confused with scrutiny and were sometimes described as ‘talking shops’, or ‘tick box’ exercises. One CE described HWBs as ‘constitutionally ridiculous’ and another interviewee argued that further work was needed over the respective roles of HWBs and scrutiny committees. Key decisions could be taken elsewhere and decisions over early intervention for children, for example, could take place in a Children’s Trust (where these had been retained) rather than at the HWB, while decisions over joint investment could be taken at joint commissioning boards. In one site, an executive group was a formally constituted decision-making body of the local authority that informed HWB discussions, but which was not held in public. In two sites, however, the public health budget had been subject to more detailed discussions in the HWB.

Not surprisingly, many interviewees expressed a lack of detailed knowledge about the budget. Those VCSE sector interviewees who were not members of their HWBs had no knowledge of how decisions on the public health budget were developed, or how expenditure and consequent outcomes were measured. The knowledge of VCSE sector interviewees who were HWB members was also limited. One spoke of how the public health budget had not been discussed at the HWB meetings. Others spoke of not recalling ‘having that discussion’, that they were ‘not aware of what’s going on with that’, or that they had ‘no idea’. One interviewee who was not a member of a HWB concluded that the system was ‘not as transparent as you probably would like it to be, it’s not as high profile as you’d like it to be’.

Another commented:

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

This had repercussions on how far the VCSE sector was able to influence priorities and there was some interest in having more detailed information presented, as expressed by a Healthwatch interviewee:

*I think it wouldn’t hurt if they shared and published right down to individual services how much they’re spending on particular services, rather than it grouped together as a big broad brush amount. So how much they are spending on obesity, how much they are spending on smoking cessation, that sort of thing. That would be really good.*

The emphasis on projects rather than on the budget as a whole was, in part, a function of how budget-setting was carried out in a local authority context, described by a senior manager as follows:

*Well, I think the way the public health savings and budgets have worked is the same as every other budget proposal across the council. So in effect we put up proposals as officers, it goes through the political process, but the debate tends to focus on individual proposals. So, you know, are we going to stop funding this service or are we going to reduce funding to X, Y and Z, rather than actually some of the debate should be the bigger picture around NHS funding, local authority funding, you know, the kind of more wider look at the system..... So that kind of political system doesn’t lend itself to having quite a strategic discussion really, what it’s designed for is recommendations that are agreed or not agreed.*

This meant that debates over how to prioritise across the public health budget as a whole were unusual, although exercises of this kind had been carried out in three sites as part of a decommissioning process. The role of elected members in deciding budget priorities was discussed in some sites and it was noted that their approach was influenced by their understanding of public health. A DPH noted:

*So I think they've just got something that has some money attached to it and they can spend the money and haven't understood that it's about really improving population health outcomes and not just improving what the people in the community say they want, but really improving their health.*

One DPH expressed surprise that officer recommendations over cuts were largely accepted by members, despite priority-setting being inevitably value-driven and therefore relevant for local debate. This DPH argued that as cuts became more difficult to implement, members would be forced to become more engaged in difficult decisions over priorities.

As mentioned earlier, the public health budget was not generally discussed at HWBs, but in executive committees. While Chairs of Scrutiny Committees had, in some cases, been members of HWBs, this had been discontinued due to potential conflicts of interest. Nevertheless, some interviewees assumed that scrutiny of the public health budget was the role of the HWB, raising questions over links across these committees and how reports of scrutiny committees were considered by HWBs.

Scrutiny of the public health budget and of public health outcomes was complex. There were differences between sites over which scrutiny committee was considered relevant for public health. This was not always the health scrutiny committee, which might be largely focused on the NHS and integrated care and in only one of the case study sites was public health included in the title of the scrutiny committee. Moreover, topics could be delegated from health to other scrutiny committees (such as the scrutiny committee for children and young people). One example of this was the possible closure of combined tuition and midwife support for pregnant teenagers, which could be referred to education or to health scrutiny. In one of the sites, the budget was scrutinised through three separate scrutiny committees (for children, health, performance and finance) as well as through the usual routes of cabinet and council. Leisure or sustainable development committees could also consider public health issues, depending on the scrutiny arrangements in place.

The breadth of public health (and dispersal of the public health budget and public health staff) meant a wide range of scrutiny (or select) committees could potentially be involved and the DPH could, therefore, need to attend a range of scrutiny committees.

This raised wider questions over how system-wide public health-related activities across directorates were to be routinely scrutinised and the level of contact between Chairs of Scrutiny Committees and DsPH (which varied from frequent to annual meetings). In one case, the breadth of the public health agenda had been considered from a scrutiny perspective and in the early period of transition, elected members (not limited to members of the health scrutiny committee) had been involved in order to foster understanding of broad reach of public health outcomes. This reflected the extent to which the public health team in this site had established public health-related programmes of work in each directorate that they could influence and possibly fund.

In general, matters for scrutiny committees were brought to the attention of elected members by residents but, in one of the sites, there had been minimal scrutiny of public health issues, as no issues had been raised. In another, it was argued that scrutiny would be limited to local authority priorities rather than focusing on indicators, such as those included in the PHOF, and in another, that more support was needed for elected members in this area. In contrast, some sites demonstrated a proactive approach with discussion of delivery and effectiveness of key public health strategies, including obesity, physical activity and drugs and alcohol. There was, therefore, a marked contrast in the extent to which health scrutiny committees adopted a proactive role in considering public health outcomes, premature mortality or cross-directorate approaches to public health.

Specific issues discussed by health scrutiny committees in case study sites included:

* Changes in public health staffing;
* Sexual health services;
* Falls;
* Mental health and self-harm;
* Loneliness;
* Food banks;
* Outcomes for recommissioned drug and alcohol services;
* Strategies for addressing obesity and alcohol misuse;
* Health inequalities;
* Causes of premature mortality;
* Exercise on prescription (including visits by Members to GP practices);
* Transfer of health visitors to the local authority;
* Health checks.

There was criticism by some interviewees of the extent to which the public health budget was scrutinised - less rigorously than scrutiny by local authorities of the NHS budget, for example. A CCG interviewee contrasted scrutiny of the PHOF with that of the Better Care Fund, with the latter monitored through regional teams, with clear targets and outcomes. This interviewee argued that if such an approach was applied to particular public health targets, spend would be protected. He noted:

 *If what were to happen after 2018 is that there was to be, say, more hierarchical accountability to the centre for delivering an overall public health target, then you could see that there would be more likelihood of a preservation of public health spending. If there isn’t, then I would imagine that the spending will be, to use ‘savage’ is the wrong word, but I think there would be significant reductions in the public health budget if the ring fence was taken away*.

***3.5.4 How the public health budget was deployed***

As a general rule, directly commissioned services for sexual health, drugs and alcohol accounted for the bulk of the ring-fenced budget and the greatest initial influence in the post- transition phase was historical spend, given contractual obligations. Once contracts expired, services were being recommissioned, demonstrating differences from the NHS in commissioning processes, choice of providers and in service specifications (described further in section 3.6.2). In one of the multi-district authorities, some of the public health budget was devolved to districts, although there was limited knowledge of the detail on the part of interviewees.

However, the public health budget was subject to a spectrum of influences and demands. At one end of the spectrum were examples of a ‘purist’ approach to the ring-fenced budget, with strategic development in control of the DPH (whether located in a separate directorate or not) and with the budget largely protected.

A DPH described the local situation as follows:

*There have been some examples where we've had to take a decision to the Cabinet member for health and wellbeing, but mostly we've been able to make any changes to how the programmes and how we use the grant, we've been able to do that within the delegated authority that we have. And other than reporting performance and progress – we do that to the health and wellbeing board and the CCG board – other than that, we haven't been required to seek approval or permission to do mostly what we've been doing. Some exceptions to that would be when we've tendered a service or retendered a service. In all cases, we've had Cabinet member approval for that and there's been discussion with the Cabinet member.*

Three sites reported arrangements along these lines. In other sites, other directorates managed part (or most) of the budget.

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

In one case, a mapping exercise had been carried out early in the transfer to identify aligned public health activity across the authority, followed by a prioritisation framework to help determine where the public health budget should be aligned. This was associated with public health delivery agreements with the directorates, described as follows:

*And it was really just, this is the amount of public health grant that is being realigned into your department; these are the potential opportunities for developing public health within your department. And in signing that, they were agreeing to look at further opportunities of improving that source. This helped develop the role of the whole council in delivering public health indicators.*

Interviewees in another site made it clear that the public health budget was used in other directorates only ‘at the behest of public health’ and that there were service level agreements in place. In a further site, the public health budget was controlled by an Executive Director, in collaboration with the DPH, while the public health team provided a public health intelligence function ‘so ... public health intelligence officers work with my commissioners in terms of obviously developing the needs assessment, the strategy, and then that develops into a specification’.

One site had gone further, establishing a public health investment plan where use of the public health grant was contingent on matched funds from directorates for spending on public health-related outcomes. The use of the public health budget as a catalyst for embedding public health across local authority directorates is further discussed in section 3.8.2.

In most sites, however, interviewees reported a range of ways in which the budget had been deployed, including the following: uncommitted money/underspends being diverted to other services; public health staff carrying out elements of others’ work due to cut backs; ‘salami-slicing’, in line with savings required by the local authority; disinvestment from current services (and ‘rebadging’ or ‘realignment’ of funds); contributions to overall savings requirements for the local authority as a whole; contributions to corporate services to reflect support for the public health team; funding Healthwatch; and varying degrees of ‘reprioritisation’, sometimes linked to priority-setting exercises exploring the costs and benefits of different options. Existing services with a public health impact, such as children’s services and children’s centres which would have been at risk of being cut, could therefore be maintained through the use of the budget. Examples of the many and varied uses of the budget include the following:

* Pump-priming the voluntary sector to promote discharge from hospital;
* Support services (commissioned through adult social care) for people with HIV/AIDS;
* Children’s centres;
* Early intervention for people at risk of homelessness;
* Alcohol rehabilitation;
* Contributing to neighbourhood networks (commissioned by adult social care);
* Care and repair through housing;
* Specialist domestic abuse services;
* Winter warmth through Age UK;
* Training volunteers for Age UK (Making Every Contact Count);
* Seed funding for tea dances;
* Neighbourhood-based voluntary sector organisation for older people;
* Working with schools with children with emotional difficulties (commissioned through the public health team with matched finding from the direct schools grant).

There was recognition in some sites that the use and reporting of the budget was ‘imaginative’ or ‘rebadged’ with ‘osmosis across the ring fence’. One CE commented that ‘a lot of the things that we would normally do we have reclassified, I think legitimately, as public health activity’ and in another site, an elected member commented that:

*we have used some of the money to basically protect some other cuts that were going to take place in the organisation around things that have a health input… public health is less safe funding-wise with the local authority than it is in the health service, because of the scale of our cuts.*

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

A major theme was that the public health budget was a primarily a local authority budget and the authority had a statutory obligation to live within its resources. Therefore, the public health budget had to align with local authority priorities and commissioning intentions. A service director commented:

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

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

In a site where Healthwatch was largely funded through the public health budget, their future funding became contingent on the budget was apportioned:

*So we don't yet know what our budget will be for 1st April because they've only just had the public health grant. So we're sitting waiting. I mean we could be decimated, for all I know. It depends how they view the public voice*.

There was disquiet over the ring-fenced status accorded to the public health budget (further discussed below) which was intensified by the extent of cuts being implemented elsewhere. This was described as ‘two different worlds’. A CE commented:

*We've got social care people managing operations, trying to reduce the costs of everything and then public health people doing things that the social care people are thinking ‘why are they doing this?’ … So I think that there was a real problem in the very beginning which public health came into. And it tended to come in to work alongside social care and the people they're working alongside were doing major cuts.*

This issue was likely to become more acute for those DsPH who were currently largely in control of the public health budget.

***3.5.5 Influences on spend***

As mentioned earlier, for many sites, room for manoeuvre was limited given mandatory and demand-led services. When asked to identify influences on how the budget was spent, interviewees cited CCG priorities, areas where the authority was an outlier, historical spend, the JSNA, the JHWS and community engagement. Main influences were summarised by one elected member as follows:

*Well you start with your strategic plans, so we have a health and wellbeing strategy. A big part of that, but also a big driver of the decisions we make we’ve then got a joint strategic needs assessment, which is a good and a living and breathing document that guides our activity. And then, you know... is your public engagement and what communities are saying they want... .You should be able to in your commissioning plans draw a straight line from the decisions that you’re being asked to make to those three things*.

The PHOF was rarely raised (unless prompted by the interviewer) but was generally described as one of a number of influences. In one site however, it was a prominent influence and the DPH stated that:

*I think the public health outcomes framework has been really good, well thought out, well communicated, and we’ve done our own analyses and presentations, so we produce information for the health and wellbeing board which is benchmarked, and we also track health inequalities as well. So we have a single scorecard that {shows} .... how we compare to our local authority comparator groups. ... .So on a single page we have something that is quite innovative so it’s really an at-a-glance guide to each of the outcomes. And we have a number of those which we boil down to priority indicators which are aligned to the joint health and wellbeing strategy and those are the ones we really concentrate on.*

A number of VCSE sector interviewees, including those who were not members of their HWB, felt that they were able to influence how the public health budget was spent. One who was not a HWB member spoke of being a member of the JSNA review board, and this providing an ‘opportunity to feed in and to have discussion and debate’ about budget priority decisions. Another spoke of the JSNA being a ‘really important’ driver of financial decision- making, leading to ‘outcomes-based commissioning’. Although not represented on the HWB, the interviewee felt that the ‘voluntary sector’s comfortable with that’. One interviewee who was a member of their HWB spoke of development sessions ‘where we’re trying to actually shape up or reshape the strategy’. Balanced with these responses were those where interviewees felt that the main influence on spending decisions was a need to make cuts, or where decisions were based on ‘political influences’.

In some sites, the JSNA was criticised for emphasising needs rather than assets, not focusing enough on education and social care or not engaging adequately with the VCSE sector and, in one case, the VCSE sector interviewee commented onlimited data on needs of Black and Minority Ethnic (BME) groups: while commissioners based decisions on the JSNA, some needs had not been ‘officially formalised or recognised’**.** In one authority, the JSNA had been changed to better reflect the experience of residents and was web-based only; in another, it was carried out on a locality basis.It was also argued that where public health was integrated into an authority-wide commissioning team, the JSNA could help underpin commissioning decisions across the authority**.** However, as described above, there were many other influences other than the JSNA on how the budget was deployed in practice.

***3.5.6 Changes in how the public health budget has been spent since 2013***

Main changes in how the budget was deployed are discussed under four main headings: preventive services; use of the public health budget across local authority directorates; public health staff; and as a catalyst.

*Preventive services*

As further discussed in section 3.6.2, once contracts were due for renewal, services were recommissioned, with an emphasis on outcomes-based specifications and value for money. Given the scale of the cuts, there were few new services. There were examples of stop smoking services being reduced and free leisure services for selected groups being decommissioned. One DPH commented:

*We might not do smoking cessation. We will certainly do a lot fewer Health Checks. We will take a lot of money out of weight management and give that back to the public and say sorry you’re going to have to go for a walk and you're going to have to join Weightwatchers like everybody else does.*

This interviewee argued that reductions in what was emphasised as a ‘transferred NHS budget’ would eventually have an impact on primary care services. However, in four sites it was emphasised that key preventive services, such as smoking cessation, sexual health services and drugs and alcohol services had been largely maintained, despite some reductions through re-procurement and that there had been no attempt to prop up other areas of expenditure. A CE emphasised that:

*we’ve been pretty good at making sure that we don’t use the public health budget to prop up other bits of council expenditure using fairly sophistical arguments...* *we haven’t put £2m into highways maintenance to reduce falls and trips*.

In another site, it was emphasised that many preventive services could be low cost, such as cycle lanes (already funded through the local authority) or park rangers taking GP referrals for walking initiatives. However, there were areas of disagreement about what constituted appropriate use of the budget for preventive services. One example of this was using the budget to fund health promotion activities carried out by the fire service, discussed in a number of sites. For example, a HWB Chair noted that:

*The fireman, actually, is regarded as everybody's friend. And so we decided to capitalise on that and we believe that building community resilience is a very important factor in our being able to make our slightly smaller resources go round and that the fire service are a unique resource to help us do that... And so we're delivering some of what might be regarded as public health work through the medium of the fire service and the communities directorate*.

This was also described as broadening the public health workforce through giving messages about keeping warm, assessing ability for self-care and liaising with other agencies. However, others questioned whether health promotion carried out by the fire service should be managed by someone without a public health qualification, pointing out that while fire services were dealing with fewer fires and therefore underused, they were not a substitute for public health staff trained in health promotion. Moreover, it was argued by a Healthwatch interviewee that:

 *that’s quite dangerous to have a sort of command and control type service*. *They’re brilliant on safety in the home and we should be working with them but … I think leading on communities is a, not a culture change for the best.*

In this case, the decision to use part of the public health grant within fire and rescue services had been made without reference to public health specialists.

*Across local authority directorates*

Given the breadth of the PHOF and the fact that almost all local authority services could be seen as relevant for achieving public health outcomes, it is not surprising that some of the public health budget was dispersed across directorates.

For some sites, where there had been a tradition of partnership working, public health funds had already been used across local authority directorates related to children’s services, tobacco control and leisure and this meant that the reforms were less of a change than a continuation. While there were many examples of the public health budget being used across directorates and with commissioning responsibility transferred to the directorates involved, in some cases public health teams acted as lead commissioner for services previously provided through other directorates (e.g. domestic abuse specialist services), the rationale being that connections could be made across other areas of public health commissioning (such as drug and alcohol misuse) with the potential to re-procure services in a more integrated way.

The corollary of reflecting a public health ethos across the local authority was a broader notion of what constituted the best use of public health investment. One DPH underlined the alignment between best use of public services investment and the need to invest in children’s services, for example, as an example of allocative efficiency as opposed to technical efficiency. He commented:

*What’s happened is people have got into quite narrow debates around the technical efficiency of where you spend the public health budgets; does it work, does it bring these outcomes, but the real debate is around allocative efficiency within the whole of public services investment.*

While recognising that the movement of public health funds to different directorates was recorded and audited, some DsPH nevertheless considered that prioritisation processes, analyses of costs and benefits of shifts in the budget and assessment of impact on outcomes were all under-developed. There were examples in three sites of prioritisation processes to determine the marginal costs and benefits of disinvestment. In addition, in one site, an assessment was made of the relative costs and benefits of saving services threatened with closure or disinvesting in specific public health services, and this was discussed through scrutiny and cabinet. A DPH commented:

 *And we tried to make an assessment about whether we thought that the benefit gained from badging the money against those services, and preventing them from closing, whether the benefits gained were greater than the benefits lost from disinvesting. And we did that as best we could.*

*Public health staff*

There had been marked reductions in public health staff – in one site the team had halved in size – and public health staff were often dispersed across directorates. In one site, for example, 80% of the grant and more than half the staff were managed by other directors. In another, an assistant director of children’s services was part-funded by the public health budget. The public health budget could also be used to fund generic support staff to reflect the influx of public health staff and services transferred from the NHS (including finance, business management, communications) as it was argued that costs exceeded the management cost allowance for corporate functions allocated in the transfer.

While the extent of the reduction in public health staff varied, it was also the case that the budget could be used to train a wider public health workforce. Initiatives included developing skills across the local authority workforce, training ‘community health champions’, supporting staff training in public health and encouraging public health involvement in pharmacies and dental practices. One site had developed a programme to help pharmacy staff (including counter assistants and pharmacy technicians) undertake public health training.In this site, there was also askills escalator for public health training. The DPH explained that:

*they need to recognise there are a wealth of talent of people within local government who would make excellent directors of public health. How are you going to get them into the specialist training programme and deploy them back into local government so that they have their training with us, but they’re going through the exam process? Because I would like to see eventually a chief exec in local government who is a public health person, you know, why not? So it’s rethinking the career route I think is important.*

This approach to developing a wider public health workforce through use of the public health budget was also emphasised in another site, where internal training had been provided and commissioning staff with an interest in public health had been funded for a Master’s in Public Health.

*Public health budget as catalyst*

The public health budget could also be used as a catalyst, encouraging joint working, leveraging CCG funds for prevention, providing pilots which attracted national funding and helping to encourage additional public health investment across directorates. One example was an initiative to address fuel poverty, where a relatively small amount of public health spend enabled additional funding from a joint commissioning board (given relevance for GP practices) which, in turn, led to investment from a national funding body. Another site was using public health funding to attract matched funding from local authority directorates.

***3.5.7 Pooling arrangements***

Most pooling arrangements across CCGs and local authorities related historically to Section 75 pooling arrangements (for services related to mental health, drugs and alcohol, children and vulnerable adults): some sites had long-standing Section 75 agreements and, in one case, a history of the local authority managing substantial contracts on behalf of the CCG.

More recently, pooling initiatives were related tothe Better Care Fund, where a single pooled budget for health and social care encouraged joint working. A number of interviewees argued that the only route left for improving efficiency was to merge and make savings across the entire health and social care budget.

Budgets for prevention were often described as ‘aligned’, rather than pooled, and the extent of pooling arrangements was, to some extent, influenced by the financial status of the CCG, which had slowed progress in some areas. There were a number of examples of joint funding related to the prevention agenda. These included:

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

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

One site noted the development of an ‘integrated wellness organisation’, a multi-specialty community provider which combined treatment, early intervention and prevention in one locality ‘wrapped around GP services’ and including mental health services. Another site explicitly linked this integrated neighbourhood approach with a preventive element, as explained by the CE:

*Through GP practices and the CCG we identified, we started off with hospital admission, avoidable hospital admission. And it’s expanded beyond that. So we identified 3,400 people initially last winter who we felt were at risk of avoidable hospital admission. And it fell into ‘not your usual suspect‘ categories. So it was not your frail elderly generally, it was quite often people aged 25 to 49 with low level mental health issues, alcohol, all sorts of other things going on. So through GP practices and what we call integrated neighbourhood teams we put in place packages of support, which included public health prevention.*

***3.5.8 Views over the ring-fenced public health budget and mandatory/non mandatory services***

The ring-fenced budget was estimated from preventative spend in PCTs and allocated to local authorities. However, ring-fenced budgets are unusual in a local authority context, limited to education and public health. While the point was made that public health had not been ring- fenced - or protected - in the NHS, this was viewed by some interviewees as a strong argument for keeping the ring fence intact, given the vulnerability of preventive services. One interviewee commented:

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

Some sites had protected the budget (and two sites had replaced funds lost through in-year cuts), despite the financial context and widespread concern that financial pressures would lead to ‘stripping out’ of the budget. A DPH commented:

*This council I can categorically say has really respected the rules around the ring fence. And I have no issues at all with how the money has been used. And this council is a council that respects if that is what central government say are the rules, then we will obey those rules. ..... Funding is being used to if you like maintain council services, but I’ve been in charge of the whole of the budget. And I know some political pressures that are around, but the ring fence itself, they’ve been utterly respected by this council 100%.*

In another site, the DPH argued that most of the initiatives carried out to meet local health needs had been possible ‘because we’ve had the money protected to do it’. In a third site, the DPH considered that the ring fence had been crucial in realising public health objectives, while at the same time realising its limitations:

*I've had the delegated authority to allocate that budget and use that budget in the way that is consistent with public health objectives. … Without the ring fence, I think, the budget would have been much more dispersed… and I would have had less control of the spend than I have had… . But the exception is that I think, like most authorities, where there has been core council budget spend on public health activities, some of the grant has been used to continue to fund those… . And I don't think there's a local authority in the country that hasn't used that device to get round the ring fence, as it were. So it's only partly effective anyway.*

The budget was described as having too few ‘checks and balances’ compared with other local authority functions, such as adult social care and education. Most VCSE sector interviewees were either not aware of the ring fence, or were not aware of how it was affecting public health spending. Of those who were aware, all felt that the ring fence should be retained because of the protection it offered from public health funding being used to support other local government priorities. One concluded that it was particularly important to protect preventive services as ‘if you cut the prevention, you increase spend in acute and primary and secondary care, without a doubt’.

Even some interviewees who were against the ring fence in principle described it as useful in transition, as an ‘awareness raising tool’, helping to ‘identify the public health outcomes that you’re achieving against the ring-fenced budget’. It was argued that the ring fence protected services, allowing time for members to fully understand and take on their new public health responsibilities. Whether it needed to be maintained, however, depended on the local authority, as expressed by a DPH:

*So you either as a council say what we’re interested in is the money, not really the public health responsibilities. Or the council says we now have a series of brand new responsibilities as a council, and we’re going to make sure we deliver them, and we need money to do that. And I think that depends on therefore the attitude of the council.*

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

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

In general, most (but not all) executive and service directors considered a ring fence unhelpful for a number of reasons: the main issue was the totality of the resource for public health and not the relatively small public health budget; a ring-fenced budget would not benefit from other funding streams (where such streams were available); it could be interpreted as signifying a lack of trust in the decision-making and priority-setting processes in local authorities; and it reduced flexibility, local discretion and the ability to align services to local needs. A DPH argued that the ring fence made more sense at a national than at a local level. Instead, the focus should be on outcomes and on activities across the local authority which promoted wellbeing rather than on specific budgets and services. A ring-fenced budget could also work against integrating public health across the authority (although some DsPH saw this as a potential threat). A CE commented:

*I can't see many arguments for keeping it, other than to demonstrate credibly to the Department of Health that we're spending public money wisely. Look, if we're cutting our budget by (x) million in the next three years, which is what we're doing, you know, why should we be ring-fencing public health from financial scrutiny when every other person I'm meeting, I'm saying how can we do this, cheaper, cheaper, cheaper, at a lower cost?*

The view of senior managers was not always shared by elected members and, in one site, all the elected members favoured a ring fence. Most DsPH and NHSE, VCSE sector and Healthwatch interviewees favoured the ring fence.

In practice, the ring fence did not prove a barrier, as services could be reclassified to align with budget reporting - more of a ‘chain link’ fence as one DPH put it.However, some interviewees were concerned that the ring fence might be needed more in some authorities than others, especially where elected members did not see public health as a priority (although most felt that in their own authority taking off the ring fence would not make a difference). The time lag between interventions and outcomes in public health meant that spend could be withdrawn before there was time to demonstrate improved outcomes, often cited as the key driver of local authority commissioning decisions. Also, it was considered to protect spending on public health, including universal services, which some perceived as less of a priority in local authorities. The main reason for retaining the ring fence, however, was the financial situation of local authorities, expressed by one CCG interviewee as follows:

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

The fact remained, however, that it was a small proportion of the local authority budget and a strategic approach to prevention across a local authority would require far greater investment than that represented by the public health budget. For this reason, some interviewees did not consider it as an important focus for attention. An elected member expressed this as follows:

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

Some CCG and Healthwatch interviewees expressed the view that there should be more transparency and scrutiny over how the ring-fenced budget was deployed and it was noted that local authority reporting categories prevailed over public health budget reporting categories. However, one CCG interviewee considered a separate budget line as ‘almost artificial’, as public health was part of an integrated offer and could not be ‘syphoned’ out. If much of the work of a local authority was linked to public health, the ring fence acted as an ‘artificial barrier’ and promoted an ‘us and them’ mentality, implying that every other local authority activity was not related to public health.

*Mandatory and non-mandatory services*

There was more ambiguity over the relevance of mandatory services, given local population needs and the importance of focusing on outcomes rather than inputs. There was also some disagreement over what should be considered as a mandatory service, with the suggestion of alternative/additional mandatory elements. Where there was a relatively small public health budget, mandated services could take up the bulk of it and the DPH in a site where this was the case argued that a ‘free rein’ was needed and the mandatory elements should be discarded. There was a view among some CCG interviewees that more value could be gained from smoking cessation services (non-mandatory) than from NHS Health Checks (mandatory) and that some of the mandatory requirements did not have a robust evidence base. Services related to substance abuse, alcohol and smoking were cited as more important than the mandatory National Child Measurement Programme. If the ring fence were to be discontinued, some interviewees considered that the list of mandatory services should be refreshed in order to afford future protection for services. One DPH commented:

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

A broader issue was the extent of local authority statutory functions and the relative status of the public health mandated services, which were less clearly specified and were mandated rather than statutory. This meant that the public health mandated services had to be viewed in the context of the statutory responsibilities of the local authority. A service director commented:

*We haven’t got enough funding really, if you look across the five year projection, there is not enough funding to fund all mandated services. So how are we going to choose which ones we do? And we’ve got to have that discussion whether we’re looking at the public health grant or not.*

As a result of potential risks to preventive services transferred from the NHS, one interviewee commented:

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

This section underlines the lack of protection for certain preventive services, as reflected in the public health budget reporting categories, including those classified as mandatory services. It illustrates broader themes of how public health is being defined and prioritised across the local authority, the relative importance attached to traditional public health services and the level of control of DsPH over the budget. It also illustrates the extent to which the current financial situation influences options available to local authorities in the sphere of public health.

## 3.6 Commissioning and providing preventive services

***3.6.1 Introduction***

The second workstream of the study concerns changes in how preventive services are being commissioned, to include new providers, community involvement, co-design and impact on uptake. Particular emphasis is accorded to NHS Health Checks (a mandatory function), follow-on services for lifestyle change (non-mandatory) and child obesity (where the National Child Measurement Programme is also a mandatory function). While innovation is difficult to measure, local authorities have the flexibility to combine, target, incentivise and remodel preventive services. They also have the potential to address some of the long-standing social conditions and contexts which make it difficult to change behaviour and exploit different ways of supporting lifestyle change. A key issue is the extent to which new commissioning responsibilities lead to innovative approaches which result in a greater impact on health and health inequalities than previously. The topic of innovation is discussed in more detail in section 3.7 and is the subject of a future research report.

This section illustrates how commissioning of preventive services is being interpreted and implemented in a new organisational context. The reforms meant that local authority commissioning arrangements were being applied to preventive services and also that these services were increasingly being considered in the context of the commissioning priorities of local authorities. Changes in commissioning processes and the nature of contracts are discussed in section 3.6.2, while links with local authority services and local communities are discussed in section 3.6.3. A discussion of how preventive services are prioritised and provided is followed by examples of preventive services, with particular emphasis on NHS health checks and child obesity (3.6.4). A final section discusses community engagement and co-design (3.6.5).

***3.6.2 Local authority commissioning arrangements***

This section illustrates how interviewees perceived differences in how the NHS and local authorities commissioned preventive services, focusing on changes in procurement processes, contract specification and choice of providers.

*Commissioning in the NHS and local authorities*

Systems of commissioning in both the NHS and local authorities were described as in a process of change, moving towards outcomes-based commissioning. In the NHS, reducing health inequalities and increasing life expectancy were mandatory health outcomes (2002-2010) for former PCTs, informed by NICE guidance for evidence-based interventions. Priority-setting was informed by health needs assessment, as the first phase of a commissioning cycle, drawing on demographic, epidemiological, social and economic data as well as views of stakeholders and communities. Public health interviewees referred to local authority commissioning as being focused on narrower procurement and contracting processes, rather than on the commissioning cycle as a whole or on pathways of care.

*Changes in commissioning processes*

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

 *So for example they {public health} would now know how much of their spend is in the voluntary sector, how much is in health, how much is in local government, how much is invested internally. ... So there’s been more opportunity to invest in the voluntary sector than there would ever have been before... So yes, the model of commissioning has changed.*

The NHS system was described as ‘technocratic’, favouring certain providers, and ‘laissez faire’ in its propensity to ‘roll over’ contracts rather than engage in new procurement exercises. Interviewees across sites considered procurement in local authorities to be more disciplined and rigorous, less ‘woolly’ and more likely to focus on value for money in achieving successful outcomes, sometimes linked to the use of incentives. Project management was described as robust, with less scope for the legal challenges commonly experienced in the NHS. In general, contracts were more clearly specified with greater emphasis on outcomes and value for money, which had led to efficiency savings as preventive services had been recommissioned. Local authorities had experience of commissioning large infrastructure projects and extensive expertise was therefore available. It was argued by one DPH, for example, that the transfer of public health to local authorities had made public health teams more focused on ‘outcomes evaluation and quality assurance’.

Scrutiny was more robust with formal scrutiny of businesses cases and market testing. This was described as a ‘massive learning curve’ for public health professionals, especially as they had not been responsible for the procurement elements of commissioning in the NHS.

Local authorities were described as less likely than the NHS to have a ‘preferred provider’ and a diversity of providers for preventive services was evident in some sites, with a change from NHS providers to the VCSE sector (or sometimes to ‘accountable providers’, acting in partnership with others). Some authorities favoured large ‘block’ contracts, including out-of-borough providers, while others favoured diverse contracts with local providers, who had ‘local knowledge and who are neighbourhood based’. A VCSE sector interviewee noted that previously commissioners would go to ‘bigger providers’, who were established members of the commissioners’ networks, but that since the reforms there had:

*been a shift towards local providers who have local knowledge, and who are neighbourhood-based. So understand the needs and the deprivation that is faced by those local communities.*

This interviewee felt that, as a consequence, commissioned services were much more locality focused. Another VCSE sector interviewee spoke of there being a new ‘willingness to try things’, a willingness to provide ‘some money and then we’ll see how it goes’.

Even for large tenders, there could be requirements to provide local apprenticeships, for example. It was argued in one site that innovation could be thwarted by large block contracts, which essentially disadvantaged community groups and smaller VCSE sector organisations. Economies of scale could lead to a dearth of innovation and, in one authority, the decision was taken to create opportunities for communities to bid to carry out innovative projects from a substantial community fund.

The ‘cosy’ relationship between CCGs and NHS providers was described as being challenged with more outsourcing: the integration agenda was also seen as a route for new providers to emerge. In one site, for example, there were new providers for all recommissioned preventive services. A CCG interviewee commented as follows**:**

 *So moving public health out of PCT and putting it into a local authority has changed the culture of commissioning. So our local authority has tendered several services, and has awarded them to non-usual bodies, including the private sector. So that’s been a shift, a different cultural shift and there’s lots of learning from that so far. So I think that’s a really different approach that they’ve taken on.... So if you look at drug and alcohol services that was a very big procurement that quite early on public health did and again brought in a private sector organisation, and working well and feels good on the ground. So you have to be open minded, don’t you, to positive changes. So yes that certainly opened my eyes to different options.*

Apart from these changes in contracting and in choice of provider, there were also differences in how services were being commissioned, with more emphasis on co-design, rather than on early specification of the contract. This was seen as a route for improving the efficiency of commissioning. A DPH commented:

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

As already reported, some interviewees felt that the reforms, combined with the impact of austerity measures, had had a detrimental effect on commissioning and providing preventive services generally, and through the VCSE sector in particular. VCSE sector interviewees were aware of changes in public health spending, mainly because these had had a negative impact on their sector. One spoke of all VCSE organisations receiving a

 *letter immediately saying we had this cut: ‘We don’t know what its impact on you will be, but we’re letting you know there probably will be one’.*

As a consequence, all VCSE sector contracts for that site were due for renewal at the end of the financial year, but the sector was still awaiting information on the new contract specifications. Another interviewee believed that the new contract arrangements were focused on saving money. Consequently, multiple services had been offered as a single contract which meant that ‘only two organisations’ were able to bid for them. They also believed that public health funding had been used to support local authority programmes which ‘would otherwise have gone under the cuts’. This experience was shared in another site, where it was felt that the VCSE was effectively ‘competing with the local authority to deliver, where they try to keep the resources in-house’*.*

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

*Changes in the nature of contracts*

There were also differences in the orientation of contracts, with interviewees describing a combination of a greater preventive element in demand-led services and better links into local authority services, such as leisure and housing. While there were few examples of new healthy lifestyle initiatives, as services were recommissioned they could incorporate a social model, peer-based approaches to changing behaviour, social prescribing and more emphasis on responding to community needs and experience. Volunteers were increasingly being used and new health-related training opportunities for volunteers had been provided in some sites. In one site, sexual health services had been recommissioned with a more preventive focus to include voluntary sector input. In another site, the weight management programme had previously been provided by an acute trust and was a dietician-led model and clinically based. The specification for the new tender wasdescribed as ‘a much more holistic, much more integrated model, much more based on behaviour change and psychosocial support’.

Sites had already (or were in the process of ) recommissioning and remodelling lifestyle services, providing an integrated service across all lifestyle-related interventions (such as exercise on prescription, nutrition, physical activity, weight management), combined with better use of leisure facilities and sometimes linked in with social prescription. In some sites, health and wellbeing hubs along these lines were already well-established. There was often an emphasis on social factors, moving from a medical to a social model of provision and a shift from ‘proximal clinical medical secondary prevention’ to interventions which recognised conditions driving unhealthy lifestyles, that is, ‘risk conditions rather than just the risk factors’. This could be reflected in the role of community link workers, described by a CCG interviewee as follows:

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

A further development was a more integrated and user-centred approach to commissioning, as illustrated by the following example related to the recommissioningof children’s services(0**-**19), made possible by the transfer from the NHS of school nursing services in April 2013, followed by health visiting services in October 2015.

 *I think the redesign that will take place with health visiting and school nursing in to a 0-19 service is looking at it from the perspective of the child’s journey rather than clinical and professional groupings so that from a child’s perspective and the family’s perspective you want to support certain vulnerable families over the journey of their childhood. You don’t want to be negotiating border points which are simply defined t by professional roles... I think, you know, in local authorities, the conversation is very much about outcomes for the community not organisational protection.*

Interviewees highlighted a change of emphasis from the health or service outcomes favoured in the NHS to an emphasis on social outcomes and assessment of social return on investment. Outcomes could include neighbourliness or reduced social disorder, for example. While the NHS was described by one interviewee as being driven by a centralised performance management regime, the lack of an equivalent regime in local authorities meant that they were more able to focus on local needs.

Concerns over new commissioning arrangements were voiced by some CCG and NHSE interviewees: commissioning was described as more fragmented (for example, in relation to obesity, although in one site, there was a single local authority commissioner for obesity services); there could be less engagement with providers; and less engagement with primary care preventive services.

 ***3.6.3 Integrating prevention into local authority priorities and local communities***

The transfer of public health responsibilities had allowed services to be commissioned in a different way, closer to council priorities and local communities and one DPH emphasised the importance of commissioning in a way ‘that has really made stronger links to other priorities within the council’.

As discussed in section 3.5, in most sites there was some integration of public health staff and public health spending across local authority directorates, with a public health perspective provided through data analysis, health needs assessments and, in some cases, through integrating a preventive element in existing services for children, vulnerable adults or support for other vulnerable groups. In relation to children’s services it was emphasised that:

 *a lot of what they’re doing in their early help, Early Years services is basically Marmot-based public health, so that’s one of the next steps for us is to reframe, what is public health commissioning, to ask, what is the commissioning of public health? …. So it’s not about the budget that we’ve brought from the NHS. It’s about, what evidence-based things could we influence and direct, but that are the spend of the whole system, not just the public health department*.

The integration agenda had led to collaboration, pooled budgets and locality or neighbourhood based teams, hubs and networks, ‘bringing public services closer at neighbourhood level’. As well as integrating community teams (primary care, social work, nursing and mental health), these could integrate police, housing and neighbourhood services. While the predominant focus was on supporting frail elderly people requiring health and social care and reducing hospital admissions, there was potential for extending the preventive element of these neighbourhood systems. Community hubs were a relatively new development, with different models for the hubs and the navigators/connectors/liaison workers connected to them. It was argued by some interviewees that preventive initiatives should be developed as part of a programme for integrating health and social care, and as part of related local networks. However, there had to be services to navigate towards, as one VCSE sector interviewee noted:

 *It’s all very well navigating but ... somebody has to then make it happen. So navigators who have no real foot in the community will struggle with that sort of stuff. But that’s a decision made, and up and down the country there are different kinds of care navigators, and they’re being run in different ways.*

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

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

*Focusing on communities*

The reforms had resulted in better linkages across preventive services and local communities. A DPH noted that members could make links across different areas of local authority activity so that, for example, healthy lifestyle services were not being commissioned in isolation:

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

Moreover*,* ‘community insight’ was described as being key to effective interventions: public health interventions needed to be rooted in the realities of local communities.

A HWB Chair noted:

 *We commission a service that links into the community and uses all those assets and advantages. So it actually changes the way you do things. It actually means you can probably achieve far more with less.*

Interviewees across most sites (including CCG as well as local authority interviewees and encompassing sites with different political control) emphasised the importance of encouraging communities (of both identity and of place) to help themselves, developing ‘community assets’ and finding ways of building community capacity, including volunteer involvement in local neighbourhood networks. It was argued that pressures on the health and social care system from long term conditions meant that communities had to become more involved, taking more responsibility in improving health and wellbeing.

Often referred to as ‘asset transfer’, was the drive to stimulate community enterprises and provide public finance to community groups on the basis of their providing greater social value*.* Sites illustrated aspectrum of approaches to community engagement, however. In one site, there were extensive volunteer networks, numbering many thousands,carrying out a range of activities including gardening, helping vulnerable people in winter conditions and addressing social isolation (helped with funding from the adult social care budget). The contribution of volunteers was recognised each year (e.g. through awards sponsored through private companies). The emphasis in this site was on community rather than on individual responsibility and was fostered by the active involvement of elected members. Initiatives and volunteer organisations were supported by small grants from the local authority, which saw itself as raising awareness for the community to take action to improve health and wellbeing and which was supported by employee initiatives across the public and the private sector.

In another site, the developmentof community assets was a promoted as an inevitable response to austerity, a route for managing demand, encouraging innovation and diversification and reducing a ‘dependency culture’, while at the same time increasing social value. This was achieved by connecting people with their communities and also replacing a grant system with a community investment fund for which community groups could apply and which was designed to pump prime sustainable community enterprises. Support was provided through community link workers (part of whose role was to map community assets), community champions, and community connectors (based in primary care). It was codified as a way of working with citizens, ‘working alongside local communities to improve health and wellbeing, improve local communities, improve community cohesion’.

In other sites, community assets were mentioned as getting ‘people to begin to understand what they can do for themselves’, for example, but without a well worked out strategy attached.

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

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

If the purpose of the public health reforms was to improve commissioning and providing preventive services, the view of VCSE sector interviewees was that this could only be achieved with their involvement and support. However, involvement of the VCSE sector was promoted vigorously in some sites but not in others.

 ***3.6.4 Prioritising and providing preventive services***

As discussed in section 3.5, the public health budget was subject to cuts and to being reorientated towards local authority priorities. Services cited as having been reduced included: sexual health services; smoking cessation services; sports and leisure; and the ‘wider preventative offer’. In one site, it was anticipated that ‘there are lots of things that won’t be funded in the future; particularly around obesity, health trainers, physical activity, suicide prevention, as some examples’. As funding became tighter the issue of prioritising spend became more stark. In one site, an Executive Director considered that, in the case of drug treatment for example, this could lead to prioritising treatment for parents, given the impact on their children and longer-term health outcomes.

Interviewees argued that the reforms had served to question definitions of public health commissioning and how it should be prioritised in a local authority context. Changes in the budget were discussed in the context of wider priorities of the local authority and also through notions of relative value. For example, the value of timely social intervention could be substantial and accrue over a lifetime. One CE noted:

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

While stop smoking services were considered a cost-effective use of resources in the NHS, for example, the same arguments did not hold to the same extent in a local authority context: A DPH commented:

 *But then when you take that service and you stick it in a local authority environment, and you look and it costs £1,000 for each quality adjusted life year, well you translate it into how much you, how many pounds do you spend per quitter who stops smoking. And you compare that to what we spend on social care, or we spend on children’s services, what we spend on our benefits services for people, and all of a sudden it doesn’t look so great any more.*

Nevertheless, it was argued that the business case for transferring public health funds into other directorates and for other purposes had not been adequately explored and a more rigorous assessment of costs and benefits was required. One DPH described a ‘belated’ attempt to do this, having been ‘mugged’.

A number of interviewees raised the issue of prioritisation in the context of individual responsibility. A service director noted:

*There is a political view about actually as an adult, not as a child but as an adult, you make independent decisions and therefore you are accountable for your own lifestyle. So therefore why should the state support you in terms of if you make a decision and there’s an implication for your decision, and that’s your decision, is one political viewpoint potentially. Versus state should be there to support, advise, intervene in terms of encouraging you and having, and being able to support you if you make unwise health choices.*

The extent to which notions of individual responsibility framed discussion of preventive services was influenced by views of elected members. For example, one DPH noted:

 *We had a workshop for elected members about the budget in the future and somebody said well everyone knows they shouldn’t smoke so I don’t see any reason at all why we should spend any money on stop smoking services.*

*Providing preventive services*

The study looked in more detail at NHS Health Checks and initiatives to address child obesity. These are discussed in turn while changes in preventive initiatives since the reforms, as highlighted by interviewees, are summarised in Box 1.

*NHS Health Checks*

Providing health checks is a mandatory function and reported as part of the public health budget. Interviewees commented on uptake in general; uptake by disadvantaged groups; and changes in who provided health checks and were they were provided - and how far such services could be maintained in the context of reduced budgets. However, many interviewees did not have detailed knowledge of the programme.

Health checks were provided through primary care (or through a GP federation) in all sites, while pharmacies were described as playing a role in four sites and another site described broader involvement through the mental health trust and health trainers. Outreach activities were described in all but two sites, covering locations such as supermarkets, town centres, workplaces and through a health check bus. One site encouraged referral to lifestyle services through an interactive programme, using tweets as reminders. Targeting activities were described for disadvantaged areas and for people with learning disabilities. In another site, the service was being reprocured in order to provide access outside working hours.

A minority of sites were highly supportive of the programme, encouraging self-management of healthy lifestyles through the activities of practice nurses or providing easy access to follow on services through integrated health and wellbeing services: one site had a pooled budget across the CCG and the local authority for health checks; another focused on at risk groups (e.g. smokers, those with pre-diabetes), identified through GP registers and linked to new integrated healthy living centres; and another had improved uptake in areas of disadvantage. In a further site, the HWB Chair had been publicised having his health check, part of a culture where elected members were involved in public health issues. In this site, the HWB Chair felt it should be less restrictive and made available for younger age groups or those on risk registers, if requested. In two sites, the local authority scrutiny committee had considered the health checks programme. In three sites, uptake was described as high. In contrast, in two sites the health checks programme was described a poorly supported or as being reduced and a further site described low uptake in areas of disadvantage, inadequate targeting and a scepticism about the benefits of the programme. In one site, smoking cessation was considered a more important service and for this reason, health checks would not be prioritised, beyond sending an initial invitation letter. Although recognised as a mandatory service, one DPH commented that ‘we will call their bluff when we come to it – that’s where we’ve reached’. In another site, health checks were considered ‘unaffordable’ as the in-year cuts to the public health budget had taken out the entire reserve and health checks had not been invested in by the former PCT.

Success of the health check programme in preventing premature mortality depends on follow-on services being available for those identified as at risk. Services included access to various lifestyle referral hubs, funded through the public health budget, which could include a wide range of services, a choice of providers and referral to other local authority services. In one site, there was a particular emphasis on the health check, improving uptake for those at risk and then linking these target groups into new integrated healthy lifestyle services (which were being recommissioned). This followed from an analysis of records from all GP practices with prevention being targeted accordingly.

Providing follow-on lifestyle services is not mandatory and interviewees pointed out that while it was mandatory for the local authority to commission health checks, it was not mandatory for GPs to provide them. As discussed in views over mandatory and non-mandatory services in section 3.5.8, some interviewees considered that the evidence base was not as robust for health checks as for other, non-mandatory services, such as smoking cessation. Moreover, GPs in some sites were described as not geared up to managing cardiovascular risk.

One VCSE sector interviewee stated that their organisation had made a bid for the contract to deliver health checks, but it had been awarded to a GP consortium and delivered through primary care. This was seen as a missed opportunity, as their organisation was involved in delivering a diabetes support programme in non-clinical settings, which had achieved positive recruitment results (‘something like 40% were coming from more deprived backgrounds’), and positive retention results.

*Child obesity*

Participation in the National Child Measurement Programme is a mandatory function and reported as a separate category of the ring-fenced budget. Child obesity (more often referred to as ‘healthy weight’) was recognised as a major problem and strategies were already developed (or in preparation) in most of the sites. There had been national recognition of local strategies to reduce sugar consumption and for system-wide approaches to addressing obesity among the ten sites. Spend on child obesity was described as difficult to categorise, however, as it did not fit neatly into the public health budget reporting categories, given spend on children across directorates and the importance of cross-directorate approaches. Programmes were delivered through children’s centres, for example, and not necessarily funded through the public health grant and there were links to physical activity programmes in schools and elsewhere as well as breast feeding initiatives.

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

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

The interviewee commented that the problem had been reported to the commissioners ‘to get them to see if they can unblock it’.

There was also some criticism of the National Child Measurement Programme, which had sometimes creating a backlash among parents. Moreover, a follow up programme was not always available.

A major benefit of the reforms in relation to encouraging healthy weight was the closer relationship between public health teams and local schools, although there could be different levels of engagement by schools within the same authority. Healthy schools initiatives and programmes were widespread, ranging from ‘healthy eating’ school meals services to child obesity programmes supported through school nursing. Other initiatives included:

* Working across early years providers on play strategies;
* Regular meetings between public health teams and head teachers;
* Using children’s centres as a vehicle for delivering public health programmes, including those for healthy weight and exercise;
* CCG funding the VCSE sector to deliver a school-based obesity prevention and programmes around healthy food choices;
* Growing, cooking and eating healthy food in schools and with families;
* ‘Food for Life’ in schools(Soil Association) in selected primary schools, with a ‘whole school’ approach to healthy eating and nutrition;
* A flexible approach to engaging with families, not limited to education or public health professionals, building on established relationships and reflecting a multi- agency approach;
* Sugar campaign in schools and a series of ‘sugar debates’, changing the school meals service contract in order to comply with sugar reduction objectives.

HWBs were not always responsible for oversight of child obesity as this could form part of children and young people’s partnership boards, where these had been retained. However, interviewees raised questions about the effectiveness of local action on child obesity, first because the evidence base for interventions was not considered strong and second because much depended on action at a national level. Obesity was often raised as an example where there was little evidence of the impact of public health interventions. One interviewee asked:

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

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

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

Nonetheless, there was evidence of elected member commitment to addressing child obesity. In one site, a Member noted:

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

Other interviewees emphasised the need for national action on planning regulations for fast food outlets and reducing sugar consumption through sugar taxes. Planning decisions related to restriction of fast food outlets were often overturned on appeal, despite Member support. Tensions between the benefits of income generation and the disbenefits of both fast food outlets and vending machines in schools had hampered developments in some sites, but in one site it was noted that discussions were now taking place on the ‘place aspect’ of people’s health as a result of the reforms.

As further discussed in the section on cross-directorate working (section 3.8.2) child obesity in some sites had been addressed through initiatives related to restricting planning applications for fast food outlets (including chicken shops) within a certain distance of schools; provision of sports and exercise facilities and working through sporting networks; working with housing trusts to provide play spaces; and working with local retailers and employers to address the wider environment promoting sugar consumption. In other sites, there was little evidence of cross-directorate action.

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| Box 1: Preventive services**Integrated healthy living/wellness services:**  a wide range of models had been developed to bring together lifestyle services previously provided separately, including voluntary sector input, GP-led, and a range of providers commissioned to provide specific services. For example, an integrated wellbeing service was described as a ‘well-used resource’ that brought together full lifestyle checks with other resources available in the council to reflect a ‘broader sense of wellbeing’ and included, for example, counselling support, health trainers and debt advice. A range of different options was offered.**Drugs and Alcohol** (a) recommissioned from a highly professionally-dependent Drugs and Alcohol Service into a more community-orientated model, also using volunteers; (b) more emphasis on peer support and looking at impact on children, combining third sector and NHS providers; (c) ‘Water angels’ promoting a glass of water after each alcoholic drink, where ‘models dressed in white with wings’ go into pubs and clubs. An interviewee noted that ‘the police love it. The bars love it. And it's evaluated extremely well’; (d) change from a traditional drugs service (with one provider), an alcohol service (with a different VCSE sector provider), plus small contracts (with pharmacists), to a single integrated contract for substance misuse. **Sexual health services**: (a) integrated sexual health services, tied in with VCSE sector for the targeted aspect; (b) use of online information, which resulted in a drop in demand for services; (c) initiatives to take account of cross-boundary issues, especially in London where accessing services in central London could double the cost to the local authority; (d) CCG funding of voluntary sector input into sexual health services; (e) moving services out of the hospital into the community (resulting in a 27% increase in people attending appointments and a 24% reduction in the cost of the appointment). **Offender rehabilitation**: restoration projects. **Care service:** provided through a community-based health and social care charity to include a healthy living centre (and including health checks). Proved successful in reaching disadvantaged groups and funded through a range of commissioners and grant-giving bodies. **Incentive schemes**: (a) social impact bond, where a proportion of the saving to the health service from a healthy living charity is recycled and pays for the activity; (b) higher rate of payments for smoking cessation for those in manual occupations. **Integrated services for children:** (a) school nursing and health visitor services and CAMHS provided in an integrated way through a private provider; (b) redesign of health visiting and school nursing, involving skill mix changes, a focus on outcomes and working across local authority services, such as children’s centres, in order to provide an integrated service; (c) Lottery-funded projects for children, to give the best start for disadvantaged children in highest demand areas. **Children and young people**: (a) online counselling services for children and young people (predates reforms); (b) healthy schools programmes; (c) healthy schools teams, a central team supporting schools, including for emotional health; (d) interactive online drama, developed through workshops, allowing young people to play out dramas online and outcomes are filmed based on the young person’s decisions. Topics include gang violence; (e) initiative across the CCG and local authority to encourage primary school children in disadvantaged areas in use of inhalers, to reduce hospital admissions for asthma; (f) recycling through a schools initiative, thereby influencing parents; (g) National Child Measurement programme followed up with family-based intensive support, taking account of social and economic circumstances of the family. **Access to lifestyle services and/or social care:** (a)telephone hub for referral to lifestyle services; (b) clearing house for referral to lifestyle services with the choice of providers; (c) advice and access to lifestyle services from shopping centre in a deprived area; (d) locality-based, one-stop-shop wellbeing services for referral from GPs, covering a wide range of lifestyle services, including depression, anxiety and obesity, and links into council services; (e) health and wellbeing hubs at district level, acting as a signposting facility and providing lifestyle (and some drug)- related services and social prescribing, working in liaison with district housing (funded through the public health grant). **Information sources:** all Citizen Advice Bureau users asked if areas of concern related to health or social care and information are communicated to local Healthwatch and through them to commissioners, if relevant to health and wellbeing.**Community facilities:** developing community centres in deprived areas (lottery funded) with a wide range of services (from selling fresh fruit and vegetables to line dancing); community ownership of leisure facilities. **Community projects for physical and mental health:** community drumming; social enterprises.**Gardening groups:** (a) using volunteers (plants provided by the local authority) which promotes exercise, improves the area and reduces vandalism and antisocial behaviour; (b) dementia day care combined with allotment/gardening activities; (c) gardening and environmental activities for people with mental health problems. **Training initiatives**: (a) training in brief interventions (e.g. for alcohol) plus an app to help those carrying them out and signposting to relevant services. **Exercise and leisure:** (a)free weekend swimming (predates reforms), shown to increase uptake amongst disadvantaged groups; (b) walking group for Asian women; (c) parks activities include guided walking, also with impact on social isolation and hard to reach groups; (d) free leisure activities on GP referral; (e) park rangers organising walks for older people (if referred from the NHS); (f) Healthy walks – could lead to development of community assets through making contacts between people; (g) joint work across district council and charity to ensure parks and beaches are well used; (h) ‘Good gym’, a ‘purposeful use of energy’, via a social enterprise, where people run between good deeds to help people referred from social services (via Instagram); (i) encouraging women to get into sport and exercise; (j) outdoor gyms; (k) healthy walks; (l) Green gym (promoted though council website); street dance in schools (funded by public health grant); exercise in school breaks and early morning exercise with teachers before school starts (externally funded); basketball court. **Smoking and tobacco control**: smoke-free play areas. **Social isolation**: (a) social enterprise tackling social isolation and ‘driven by local entrepreneurs’ and where referrals can be made through health and social care (public health funding used as catalyst); (b) library-based activities (e.g. knitting groups); (c) developing community capacity and setting up community groups for befriending services and supporting development of community centres. **Food and healthy eating:**  (a) raising awareness about sugar; (b) volunteers setting up ‘cook and eat’ sessions in community venues; (c) targeting weight management services in areas of high deprivation; (d) contacting restaurants over levels of salt and fat; (e) encouraging local food manufacturers to produce healthier food (e.g. healthier pies); (f) further development of weight management services and single access point for residents for a wide range of weight management programmes offered by different providers and also targeted to groups less likely to engage; (g) growing food in schools for school kitchens; (h) free hot meals in park, run by volunteers, in a deprived part of the borough; (i) community-based diet and physical activity service; (j) food summit (including public health and the voluntary sector); community food classes (as part of adult education), bringing families together. **Heart Health**: borough-wide initiative. **Healthy business awards****Social prescribing:** (a) community link workers in primary care; (b) social prescribing funded by CCGs and delivered by the voluntary sector; social prescribing project, mainly for people with mental health problems. **Targeting of services:** (a) targetingservices to ensure higher take up from those with greatest levels of need; (b) health trainer services only available in disadvantaged areas of the borough. **Wider public health workforce**: fire service providing health promotion. |

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

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

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

***3.6.5 Community engagement and co-design of preventive services***

One of the rationales for the reforms was that local authorities were closer to local communities than the NHS, with well-established routes for community engagement and co- design. Some interviewees considered that public health services had often adopted an intervention model which involved ‘doing things to people’ rather than working with them and that interventions should be rooted in broader community-based activities already in place.

Local authority engagement mechanisms were extensive. At a general level, this was promoted through member involvement in their wards and local area committees. There were also specific consultation mechanisms for particular groups. For children, for example, there could be a youth cabinet, youth forum and school councils, parent/carer groups in children’s centres, a children in care council, involvement of parents and young people in designing services for children with disabilities, initiatives to involve young people in mental health services redesign and electronic systems for user feedback for children and adolescents. More generally, there were citizen’s panels and groups for those with particular needs, such as people with learning disabilities and parents and carers of children with disabilities*.* Other routes for engaging with local people included community health champions, patient participation groups, and members of Foundation Trusts, faith networks, amateur sports clubs and ad hoc targeted groups.

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

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

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

Interviewees highlighted greater engagement since the reforms in relation to the JSNA and co-design of services.

*Community engagement in the JSNA*

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

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

A VCSE sector interviewee from a site that did not have VCSE sector representation on the HWB nonetheless believed that there was now wider stakeholder engagement and co-production, giving an example of the process to refresh the JSNA. The interviewee was a member of a JSNA review board and consequently had an ‘opportunity to feed in and to have discussion and debate’. The ability to influence was mentioned by other interviewees, through public health attending VCSE forum meetings, consulting on the JSNA and through face-to-face meetings with small groups. However, there were also interviewees who felt that there was less ‘ongoing dialogue’ and fewer opportunities to influence. One interviewee also observed that, even though public health had a culture of:

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

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

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

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

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

*Co-design of services*

One reason for community involvement was to establish priorities for funding through finding out what support was needed and where services could be delivered differently. Commissioners needed close links with communities in order to develop the new community hubs, for example. There were examples of co-design across midwifery, youth and mental health services along with web-based services created and designed by young people. Other examples of co-design highlighted by interviewees are included in Box 2.

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| Box 2: Examples of co-design* ‘Experts by experience’ programme in adult social care;
* Services for sexual health and for drugs and alcohol: ‘a co-design piece ... I think the drugs and alcohol one was probably the most recent one where people were more actively involved in it’;
* Substance misuse services: (a) ‘substance misuse service, domestic violence service will be co-designed absolutely with a strong input from the beneficiaries, even bigger than that, the perpetrators in terms of some of the services’; (b) redesign of a substance misuse model of delivery via a co-productive approach which led to a revised local substance misuse Integrated Prevention and Recovery model and informed a new tender; (c) recovery model for a drugs and alcohol service where those in recovery volunteered to support the next group coming through;
* Recommissioning of CAHMS where young people had been fully involved and which had led to a different delivery model and a different provider;
* Working with over 100 organisations to help design healthy lifestyle services;
* Healthwatch initiatives through specific engagement contracts and work with young people and seldom heard groups;
* Engagement work by public health over 6 months for an ‘emotional health and wellbeing JSNA’ included work with Asian heritage young people who were trained as ‘engagement practitioners’. These young people then recruited and carried out interviews with 25 other young people from their community or social networks. Interviews were audio taped and transcribed, and this data was then included in the final analysis.
* Network approaches to identifying social and economic need involved mapping of social networks, assets and health profiles in a ward area to understand how local social networks could stimulate new responses to addressing health problems, and new ways of growing local enterprises. A team of community researchers surveyed local residents and local residents were involved in interpreting and making use of the findings. A range of latent community resources was identified.
 |

An elected member noted that while communities might not understand that they were involved in developing new services, money was being used to support community groups:

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

This could address problems such as social isolation, identified as a problem not just for older people but also for young people and recognised as having implications for public health. Co-design could itself lead to the development of community assets and the links between them was illustrated by one interviewee in relation to dementia support:

 *I never quite foresaw the extent to which they would then become assets in their own right. You know, so they are people who are now going on to set up their own community interest companies and they're becoming dementia trainers and they're getting jobs and it's fantastic, really. So some of that experience of co-production in adult social care, I'm now trying to bring that same type of thinking and certainly we're doing it with the NHS, but actually I'm trying to position it as part of our Stronger Communities work as well.*

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

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

In summary, commissioning decisions are influenced by a wide range of factors from budget constraints at one end of the spectrum to views over the value of lifestyle interventions at the other. There is evidence that specific preventive services are being recommissioned and sometimes reduced and that mandatory programmes such as the health check are not necessarily being prioritised. The point was raised by some interviewees that commissioning specific preventive services could revert to the NHS as part of the whole patient pathway, otherwise the budget could continue to be eroded and there would be further fragmentation with primary care preventive services. The cost-effectiveness of smoking cessation in the context of local authority priorities and services was questioned as was the evidence of impact of interventions for obesity. However, there was also evidence of more emphasis on social and community elements of preventive services and of a wider range of providers.

There was increased use of the voluntary sector and development of community assets with attempts to integrate a more preventive element into services across local authority directorates. However, there were clear differences between sites over the extent to which the VCSE sector was seen as a major route for understanding and engaging with communities. In two sites, there was more emphasis on the role of the local authority in directly engaging with its communities rather than the role of the voluntary sector and this was reflected in the membership of the HWB where the VCSE sector was not included.

There was variation across sites in relation to the emphasis on preventive service and on the balance across individual responsibility and social context. Both views could lead to disinvestment in certain preventive services, such as smoking cessation. As described in the previous section, there was also variation in the extent to which the public budget had stayed intact – for the present at least.

## 3.7 Innovation

***3.7.1 Introduction***

The Public Health White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England* (Secretary of State for Health, 2010) makes clear the extent to which the public health reforms were expected to result in innovation. Through the ‘radical shift’ represented by the reforms, local government and local communities would be placed ‘at the heart’ of improving health and wellbeing and there would be freedom to innovate in the ways that public health services were provided in the context of localism and local needs, rather than through central government performance management regimes. It was planned to introduce financial incentives to reward progress against outcomes in a new PHOF through the health premium incentive scheme (although this was discontinued following the pilot year).

The While Paper adopted a lifecourse approach for improving health and tackling health inequalities (‘Starting well’, ‘Developing well’, ‘Living well’, ‘Working well’ and ‘Ageing well’). This was reflected in an emphasis on ‘key transitions’ and on the importance of not tackling individual risk factors in isolation. There was an emphasis on involving new partners, including charities, voluntary organisations and community groups, ‘as advocates for excluded groups and catalysts for action’ and on incentivising improved outcomes.

The theme of innovation therefore runs through the study as a whole and is particularly emphasised as one of the research questions addressed as part of workstream 2, that is, ‘Have new public health responsibilities led to innovation in the use of providers, in co-design, in targeting strategies and in models of provision?’

Questions related to innovation were included as part of the interview schedule for case study sites, in initial interviews with national stakeholders (Research Report 1) and in three surveys carried out to date (and reported in Research Reports 3 and 4). This section focuses on definitions of innovation (3.7.2) followed by sources of innovation highlighted by interviewees (3.7.3). Further discussion of innovation arising from project findings as a whole, to include links with public sector reform, will be discussed in a separate research report on innovation.

***3.7.2 Definitions of innovation***

Interviewees were asked a broad question – to briefly describe how they understood innovation in public health. Many answers fell into generic rather than public health-specific categories, such as ‘strategic leadership’, ‘trying out new things’, ‘improving outcomes for less money’, ‘improving services’, ‘thinking outside the box’ and ‘using technology’. Innovation was described as a ‘cast of mind’, rather than a particular procedure or related to a specific discipline. For the VCSE sector, definitions of innovation were often similar to those of statutory sector interviewees, with agreement that ‘innovation’ meant doing things differently in order to achieve better results. There was also the view that innovation was not necessarily something to be sought after in public health, as ‘keeping people healthy’ was achieved through doing things which were already tried and tested. One VCSE sector interviewee considered being healthy relied on ‘common sense’, rather than innovation:

*It’s simple isn’t it, it’s about all the things that we do, a healthy lifestyle. We know that. So I really struggle with how we can be innovative or come up with innovative ways to keep people healthy. I think it’s common sense. Our innovation has been in partnerships, and in being flexible within those partnerships, and being creative with small amounts of money to maximise the impact of what we can do.*

The importance of experimentation was emphasised, as opposed to what was described as the tendency of professionals to 'draw funding to themselves'. A CE commented that:

 *I'm very much into trial and error and experimentation, learning as you're doing at the local level with the people that we have and the people whose problems we are here to solve. Most people solve most of their own problems. When they don't, they get together with other people with problems like themselves and try and solve them socially, so we can help that as well. And when that doesn't happen, they look to the state to help solve these problems through policies or through instruments or through special programmes.*

Sometimes innovation was associated with implementation, particularly cost-effective implementation. As one DPH put it: ‘it’s not an innovation until it’s happening’ and it was also pointed out by an interviewee from the VCSE sector that most things worked well ‘because they’ve been tried before’. It was important to learn from good practice, through developing ‘communities of practice’, for example. Innovation was also supported by the LGA and some sites were closely involved with their programme.

Working through partnerships and across disciplines was seen as a key route for innovation. The integration agenda was often cited as leading to new partnerships and collaborative commissioning, although the extent to which prevention was included as part of this agenda varied across sites. It was emphasised by a CCG interviewee that ‘if you have the right relationships, irrespective of organisations, you can still do really innovative things’.

A common theme was the impact of austerity on innovation, summed up by one CE who noted that ‘what public fiscal austerity does to local government is it forces it to be innovative’. Traditional approaches to innovation such as ‘setting up a programme and funding a worker to develop activities’ were no longer considered feasible, due to a lack of resources. While some interviewees considered that outcomes could be improved at the same time as costs could be reduced, some authorities were more affected than others by changes in budget allocations. Interviewees from district councils, for example, did not have the challenges of demand-led budgets for children’s services and adult social care. The impact of cuts on local authority services in general and public health services in particular was emphasised in most sites. As with many statutory sector interviewees, VCSE sector interviewees recognised a link between innovation and austerity measures. One felt that the harsher commissioning environment which had arisen from austerity measures had led to an increase in innovation, stating:

*When you’re getting grants year on year, there’s not the necessity to be innovative. When you’ve got a position whereby you’ve got to try to apply, it makes you evaluate and look at how you deliver that service to try to fit their needs.*

One interviewee spoke of how increasing cuts within local government had led them to focus on priorities and consequently had ‘actually driven some really innovative thinking across the third sector and the local authority’. Another stated that the hardened financial situation had:

*encouraged innovation in a rather awkward way, in the sense that the austerity has meant that to continue to provide what you see as priority ... you've got to be innovative.*

Another VCSE sector interviewee did not share this view, believing that innovation was being prevented as a result of austerity measures, which had led to the cessation of small grants and the introduction of inflexible commissioning structures which focused on big contracts and so excluded small, more flexible, organisations. However, as already discussed, this experience of ending small grants for pilot projects, or of having commissioning arrangements which excluded small organisations, was not shared by all interviewees.

Changes due to austerity were also linked to issues of ‘transformation’ in the public sector more generally. Comments on the effects of austerity on innovation should therefore be considered in this context.

***3.7.3 Sources of innovation***

While there are many ways of approaching innovation, responses from interviewees suggest the following main sources.

First of all, innovation arose due to the very fact of public health teams being located in a new local authority context. A CE commented:

*I think there has been more (innovation) because what we’ve enabled since the reforms is a specialist public health team with an opportunity to use their skills, knowledge and evidence to directly influence the thinking and debate of politicians and very senior managers across a diverse range of services in local government, from schools and education all the way through to street collection, refuse collection****.***

Of key relevance was the potential for innovation not just through influence but through ‘synergy’, that is, bringing together the different approaches of public health and local authority executives and members. An Executive Director commented:

 *Where we all come from different professions, if you all respect each other and bring that knowledge and expertise and ideas together, it can be a fantastic combination.*

Public health teams were often engaged across different directorates of the authority, providing data, evidence, advice, health needs assessments and promotion of a public health perspective in decision-making more broadly, including assessment of the return on public health investment. Benefits of this approach and the innovation it had led to were reflected across a number of sites. One DPH commented:

 *How can we put added value into what the council is already doing, with a public health hat on? And that is largely around what's the evidence base? What are the outcomes? How can we actually get more for our money? How can we help improve the lives of people through our contribution? So I think that is the innovation and it's happening everywhere across the council to a greater or lesser extent.*

Public health teams had been able to draw on local authority resources, such as communications teams to publicise authority-wide public health initiatives across the local area. A HWB Chair in a site with a particularly proactive communications team noted:

 *It's about getting a life story around it as well, you know, making it relevant, pertinent to people so they want to read it.*

This increased the outreach and relevance of public health initiatives.

Second was the importance of ‘starting with the user’ and with local communities. Engaging with communities was seen as a *sine qua non* of innovation in some sitesand it was emphasised that creative solutions came from people and their life experience and from engaging communities to create individual ownership and responsibility for life change. As one CE put it:

 *It’s a general understanding over time here that … if you’re going to find creative solutions to some of the issues we’ve got, the answers aren’t in the town hall are they? …. We need to work with people in order to get them.*

Interviewees cited examples of DsPH being more receptive since the reforms to trying out innovative ideas that had emerged from communities via the VCSE sector, as well as working in new partnerships with the sector across issues such as winter warmth. It was also argued that learning from elected members was more likely to lead to innovation than a top down performance management approach and that non-experts needed to be engaged in debates over effective interventions. Linked to community engagement was the potential for innovation from co-production, which could, in turn, lead to the development of community assets. An example of this was a recovery model for a drugs and alcohol service where those in recovery volunteered to support the next group coming through, so **‘**you’re strengthening the approach of that whole community, and taking that forward’.

Third and related to the above was the importance of localism, rather than central government direction, governed by members, and, according to a DPH, leading to a ‘very dynamic conversation going between the politicians and the officers about how best to use the resource in a way that gets the public attention, that tells a good story about how things are improving’.

Fourth was the importance of innovation through contracts and through commissioning, described as more easily achieved in local authorities than in the NHS. This could include remodelling services, reaching targeted groups, working with different providers or through preventive services developed elsewhere being implemented at scale. For example, one CCG interviewee noted:

 *We may have combined two or three people’s ideas together, which nobody else has ever done, and we’ve often industrialised it which might be new. Often an area might trial something in a very small way. We’ve taken it up into a much bigger space.*

Fifth was the incorporation of local authority staff into a public health workforce (such as the fire service), the adoption of *Making Every Contact Count*, and the creation of referral pathways across, for example, housing officers and health trainers. Developing an innovation culture among staff was stated as a key priority in one site. This could be aligned with staff training to recognise the needs of different groups, so that services were not developed in a top down or bureaucratic way but reflected the needs of local communities. For example, a HWB Chair noted:

 *So it’s about developing that culture right through the organisation. Right down to the frontline, so that frontline staff feel safe that they can try something new, do something new. I said I’d like you to evidence it as you go along.*

Basic and more specialised public health training was being developed, reflecting the importance of a public health approach being incorporated across all local authority activities, as well as of ensuring a sustainable public health workforce. One CCG interviewee noted:

*Every Contact Counts is an innovation. So there is a very deliberate approach to trying to, for all the workers that the council either employs or commissions, for them to target just a limited number of areas in each of their consultations, accident and fire prevention and also smoking cessation. So they’re very, very clear things that anybody going into a patient’s home can affect.*

Sixth was the use of technology, not just for online services (such as for counselling, or advice on sexual health), online resources and reminders, or use of skype for consultations but through using IT specialist staff in new ways. One example was helping older and disabled people make choices about where to live or in reducing social isolation. There were also innovations in data management: in one site, data were being pooled so that service utilisation across a whole patient pathway could be analysed. This enabled ‘business cases for risk share and gain share’ around investment and ways for negotiating how action in one part of the system could impact on another. In one site, a way had been found of pooling data so that a whole patient pathway could be analysed, with the ability to measure service utilisation across the pathway and the potential for assessing how action in one part of the system could impact on another and then reflecting this in how money saved was apportioned across partners. A CE from a different site commented:

*If you were really innovative, and this is my view of it, is that if we significantly reduce spend in the NHS, and I know it’s got a long way to do that, then the NHS might invest in some of our preventative services … so you’ve got to see the system as a whole. And where local governments see their bit there and health there, they make a mistake in my view, a complete mistake. And we don’t look at it like that*.

Seventh was the use of innovative incentive schemes, such as a ‘Social Impact Bond’. An example was cited where a health and social care charity, providing a range of care services and a healthy living centre, received a proportion of the NHS savings it had made possible and thereby increased its social value. The potential for using the social value act in contracts was rarely raised across sites, however.

Also highlighted was the importance of research-led innovation (by some NHSE interviewees). In one site, there were plans for an innovation partnership across the CCG, the local authority and the voluntary sector, ‘to deliver a range of services in local communities to build community capacity and self-reliance’.

Barriers to innovation were also voiced. Procurement processes of local authorities could work against innovation, making it harder to trial projects with small amounts of funding. The concern to separate commissioning and provision also made it more difficult to engage with providers in advance of specifying contracts, in order to develop ideas. There was also some criticism of the failure to build on findings from studies funded by Big Lottery, for example, in commissioning strategies, even where public health outcomes had been improved. An interviewee noted:

*Big Lottery invests a lot of money in these sorts of programmes… public health outcomes are achieved in many ways but to actually get a join up between a service that is trialled by the Big Lottery and then commissioned by public health or the CCG or whatever that just doesn’t happen in many cases. So you get lots of very innovative project work going on that then just dies on the vine because there’s no sustainability.*

There were tensions across evidence and innovation. A CCG interviewee expressed this tension as follows:

*So when you innovate you’re, it’s going with your hunch. You’re saying what we’re doing at the moment isn’t right. We’ve got to do something different. So define that in public health. I think what we tend to do, what tends to hamper innovation generally, and I don’t know whether this is more or less a public health matter, is our desire in the health system to be evidence-based. But you can’t get the evidence without innovating.*

While many of the initiatives highlighted by interviewees were not innovative in the sense of being completely new, their adoption as part of the new public health responsibilities of local government gave them added force.

## 3.8 Commissioning across a public health system

This section considers interviewee views over public health challenges (section 3.8.1) and then discusses cross-directorate working and system-wide approaches (section 3.8.2), progress in collaboration (section 3.8.3) and how the reforms promoted collaboration in some areas but had led to a degree of fragmentation in others (section 3.8.4).

***3.8.1 Addressing public health challenges across a local system***

Interviewees identified many public health challenges. There were challenges related to deprivation, premature mortality and health inequalities; risks associated with obesity and particularly the long-term impact of child obesity; and long-standing problems associated with smoking, alcohol and drug misuse. Infections such as TB and the late diagnosis of HIV were a cause for concern and mental health problems, particularly among young people, were often cited. Interviewees also highlighted challenges arising from social isolation, domestic violence, crime, needs of migrants, homelessness, lack of readiness for school and troubled families, reflecting a breadth of approach to what constitutes a public health problem. Apart from its intrinsic value, interviewees also emphasised the importance of preventive action to manage demand and reduce costs for the NHS and local authorities.

In most cases, addressing these social and health challenges requires as a minimum a degree of collaboration across local authority directorates and across local authorities and the NHS, and as a maximum, coordinated action across partners across a whole system. It implies alignment across the strategies of the local authority and the CCG and shared objectives (sometimes reflected in pooled or aligned funding). While the HWB is one channel for this alignment, greater emphasis was placed on the integration of health and social care, where the Better Care Fund had promoted joint objectives and approaches: the development of coordinated and partnership approaches for public health challenges was less marked.

As further discussed in section 3.9, leadership across a public health system also requires public health teams to work beyond the local authority and, as described by an NHSE interviewee, to act as a ‘key player in influencing and negotiating and working across the system’. In this context, a DPH questioned an emphasis on commissioning preventive services, preferring to focus on the importance of influence and leadership across a system:

*Is commissioning of services where public health should put its focus? Or should it be about having a skilled public health workforce that can influence others and lever in money that way?... So it could be that as time goes on we focus less on commissioning of services, and much more about capacity building, influencing and our leadership role.*

The remainder of this section considers key aspects for working across a local system.

***3.8.2 Cross-directorate working***

Greater influence over wider determinants of health and health inequalities, one of the key rationales for the transfer of public health responsibilities to local authorities and considered a key advantage of the reforms by interviewees, involves working across directorates, including housing, planning, licensing, income support, employment and environment. This provides an important element of a whole system approach to complex public health problems. Interviewees discussed how this approach could be reflected through the breadth of a JSNA; the involvement and influence of the public health team across directorates; the breadth of HWB membership and debate; routine use of health and health inequalities impact assessment and, for multi-district authorities, coordination across districts and county councils.

*Broadening the JSNA*

While commissioning has often been associated with procurement, commissioning for health and wellbeing implies a continuous cycle of activity, involving needs assessment, priority-setting, monitoring and evaluation. A broader and cross-directorate approach to developing the JSNA was implied by the nature of public health challenges and some interviewees criticised the JSNA for its narrowness, its lack of focus on education and social care, for example, and its emphasis on needs rather than assets. It was argued that where public health was better integrated into an authority-wide commissioning team the JSNA could help underpin commissioning decisions more widely across directorates and also promote cross-directorate working.

*Involvement and influence of the public health team across directorates*

There was variation in how cross-directorate working was interpreted, implemented and coordinated across the sites. Involvement of public health teams within specific directorates could help raise the question of public health impact across the range of services provided and there was also a broader advocacy role for public health teams, working across directorates. While involvement of public health staff in directorates for adult and children’s services was common, there was less evidence of involvement in highways, environmental services, planning or regeneration: local government was described by one elected member as a ‘slow moving beast’ in this respect. However, in some sites, ‘acceleration’ of cross- directorate working was described, with an influence over local authority strategies and plans which had not been possible previously, even where DsPH were joint appointments. There were close links with culture and leisure services across a number of sites, with the DPH holding the budget for leisure services in one site. This increased the potential for influencing a wide range of plans and strategies. In another site, an internal ‘public health board’ had been set up, where all the main directorates of the council were represented. This was described as a ‘sort of oversight governance around public health function and budget’ enabling ‘cross-council officer discussion’. This had resulted in closer involvement of the public health team in the directorate for growth and regeneration. In addition to this, there was a HWB programme board, broader than the HWB, chaired by an Executive Director, and incorporating ‘movers and shakers’ across the authority.

However, in one site, a more systematic approach had been adopted to reflect and build on the authority as a ‘public health council’, including all directorates and not limited to the use of the public health budget. The public health budget (via a ‘social determinants of health fund’) was used as a catalyst for other directorates, with regular reporting on targets, as agreed in a public health delivery agreement. This fund had two aspects. First, each directorate was asked to provide specific public health services (sometimes funded through the public health budget as a pump priming mechanism, and sometimes through negotiation as part of its mainstream provision). This was described by the DPH as a way to ‘stimulate the thinking within the department, almost buying public health outcomes from them on a performance basis**’**. Second, directorates drew on their own mainstream budgets to contribute to extra outcomes in the PHOF, thus promoting the mainstreaming of public health outcomes within local government performance. This was reflected in a formal delivery agreement with each directorate and performance monitoring of public health outcomes with regular reporting through elected members. The HWB Chair commented:

*Every portfolio holder has to take that report to the … senior policy team meeting, where executive members and his lead member are sitting together..... So I think when we’re talking about the whole system, the whole council is thinking that public health is our responsibility. That’s where responsibility and outcomes come back to every portfolio holder… every director is responsible for five outcomes from that patch of money. So I think the system in place, that whole council has taken public health is our responsibility.*

This was perceived as increasing the understanding of how local authorities were already contributing to public health and working to improve outcomes. The DPH emphasised that:

*we need to change the culture of other social systems so that they generate health as an added value, the way they do daily business, not get better and better at finding money for secondary prevention, which is an investment in the disease once it’s already arisen.*

However, as in other sites, existing public health-related activity under threat from cuts was supported by the public health budget. In one site, it was noted that one driver for looking across directorates had been to determine how the public health grant was being spent.

*Breadth of membership and debate in HWBs*

To some degree, commitment to a cross-directorate approach was reflected in the breadth of HWB membership and the extent to which wider public health issues were discussed. In one site, HWB membership included representatives from the VCSE sector, police, housing, the crime and drugs partnership and providers. One HWB had included discussion of wider issues such as sustainability, air pollution and housing and another, the extent of food poverty as a consequence of austerity. However, not all adopted this approach and in one site, it was noted that the tobacco control work would not go to the HWB ‘because it’s higher level than that’, illustrating not only variation in the breadth of discussion but the relationship of the HWB to other partnerships.

*Health and heath equity impact assessment*

The use of health impact assessment has been recognised as a tool for embedding public health into local government decision-making. In two sites, it was already being carried out and in another, health equity impact for all local authority policies was being considered. A DPH commented:

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

Another DPH described the change as follows:

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

However, it was also argued that routine requirement for equity impact could turn into a ‘tick box’ exercise, so much depended on how it was carried out.

*The role of District Councils*

The key role that district councils can play in public health has been recognised, given their responsibility for housing, leisure, environment, planning and licensing. Questions were raised over links between districts and public health teams, coordination of public health services and how far public health priorities agreed at the HWB, for example, were reflected in district priorities.

The study showed a limited focus at a county level on the public health potential of districts in relation to wider determinants of health and, conversely, limited ability on the part of districts to influence county priorities. A district councillor commented:

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

While public health was described as being included in the corporate plan of districts (and, in one case, districts had their own, informal HWBs), districts were often described as working at an individual level, funding public health services out of their own budgets with initiatives which were often individual and lifestyle-based (e.g. fun runs) or wider community-based projects. One district councillor noted:

*One of the things we’re doing now we’ve just updated our objectives to make it even more community-focused so that we’re getting communities, community organisations, community associations to take ownership of their community and also the outcomes within their community of different strands ... of health, wellbeing etc.*

In one site, districts were being funded through the public health grant to implement services, with designated public health leads for each district. This meant there was a ‘locality feel’ to the work. In another site, health and wellbeing hubs had been set up at district level, signposting, providing lifestyle services (including some drug-related services) and also some social prescribing, liaising across housing and leisure (although it was noted that further networking, for example, across children and family centres would be desirable). District councillors were involved in these hubs as board members. However, despite these initiatives, one interviewee argued that there was little evidence of coordination, either across districts or between districts and the county in relation to public health initiatives, noting:

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

While districts had been provided with public health funds, it was argued that there was little consideration of potential duplication of lifestyle services already funded through the county or provided through the voluntary sector. It was argued by one Healthwatch interviewee that Healthwatch needed to get more closely involved at a district level:

*Where we're looking to go for the next three years, our next sort of strategic thinking is to get close to the voluntary sector, closer to the districts. I think we've achieved, you know, the higher level relationships we've sort of established*.

Some interviewees argued that working across districts and local CCGs could be improved and there were examples of CCGs meeting with district councils to discuss plans. However, fragmentation across districts made collaboration more difficult. VCSE sector interviewees from areas with multi-district authorities made reference to these challenges, which derived in part from diverse characteristics of the individual district councils and partly because of the numbers involved. One noted that:

*district representation (on the HWB) by elected members has always been more an attendance than an active role, the two I’ve known. That may be because they haven’t had, nobody’s briefed them too well or most district councillors are interested in their district and if it doesn’t affect them...*

As discussed in section 3.9, engaging and collaboratively leading public health across county and district areas of responsibility presented challenges for all multi-district sites.

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

*I think it probably works better in a unitary, because you’ve got things like housing, environmental health, public protection all there in one organisation, whereas with a county council two tier you’ve got to maintain that relationship with the districts as well as the county function. So I think it’s a bit clunky in terms of the relationships. So it means that we have to use more of our staff time doing that relationship building across the different levels, the different tiers of government, and I think that puts an additional burden on us.*

Box 3summarises some examples of cross-directorate working highlighted by interviewees.

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| --- |
| Box 3: Examples of cross-directorate working**Tobacco alliance:** (a) In one site, a new tobacco control strategy had been launched (with extensive media coverage) involving an alliance across partners and all departments of the local authority. This included further bans on smoking in public places, including smoke-free outdoor play areas, cited as an example of health benefits to children which involved low cost to the authority; (b) ln another site, a tobacco control alliance was chaired by the CE and included the fire service, the police, trading standards and youth services (and linked in to the health inequalities strategy); (c) a campaign against illicit tobacco working with trading standards. **Alcohol strategy**: includes ban on outside drinking in public places.**Food:** local food summits.**Planning:** (a)regulations on fast food takeaways within 400 metres of a school; (b) objections to opening of a betting shop; (c) public health input into planning new builds and assessing planning applications from pubs.**Contractual changes:** (a) including healthy vending machines as part of leisure contracts.**Transport**: (a) 20 mile an hour speed limits on side roads across a city; (b) funding transport department to work on cycling proficiency in children (public health budget). **Housing and public health**: funding ‘warm homes’; removal of ‘no ball game’ signs from Housing trust properties. |

Barriers to cross-directorate action derived from outsourcing of services, such as education and housing, and the risk of local planning decisions on fast food outlets, for example, being overturned on appeal. While many issues needed changes in national policy, a Healthwatch interviewee noted the need to ‘build up an agenda locally that can influence nationally’.

Other factors that worked against cross-directorate action on the wider determinants of health, included a tendency on the part of some elected members to consider health services as having a greater influence on public health than the wider determinants. In addition, scrutiny of cross-directorate working was limited and made complicated by the fact that different scrutiny communities could be involved and it was not clear where cross-directorate approaches, per se, were considered.

***3.8.3 Working across partners***

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

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

Lack of co-terminosity across CCGs and local authorities, especially in multi-district authorities could create problems in collaboration, as could the fact that CCGs might relate to different acute providers. A HWB Chair noted:

*They look to different acute health economies and they naturally all have their own priorities and targets for their populations, which, because they are for a part of the population that we cover, are not necessarily exactly the same as ours. So I think as the CCGs develop, in a very positive way, and begin to change the shape of services that they are commissioning for their populations, there is a challenge for us to keep it within a county-wide framework.*

Such problems were less evident in unitary authorities with a single CCG. The reforms did not take adequate account of two tier systems, being most suited to ‘neat, coterminous single-tier areas’. Moreover, CCGs were sometimes divided into localities with different approaches.

Working more closely with the VCSE sector was an aspiration of the reforms but was variable across sites. VCSE organisations were represented on the HWB in five of the case study sites. All interviewees who were members of their HWB had been elected to represent their sector, rather than identified and invited to do so by the local authority. However, interviewees spoke of the difficulty of fulfilling this duty when the sector was so diverse and the infrastructure and associated resources for doing so were minimal. One interviewee summed this up:

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

Assuming the HWB role could cause tensions within the employing organisation as it took resources, which were already limited, away from core business. However, interviewees who were members of their HWB valued the role, and there was an awareness that it was an opportunity not afforded to the VCSE sector by all HWBs. One reflected that it was:

*good to have been given the opportunity to be at the table, and that the voluntary sector need to be there. … So we’re grateful for the opportunity and therefore do try to make a commitment to it.*

Interviewees in areas where the VCSE sector was not represented on the HWB were equally aware of the need to engage with other stakeholders involved in health and wellbeing. One interviewee felt that representation was ‘absolutely critical’. There had been VCSE sector representation on their HWB in the past, and the interviewee was aware that debates were taking place ‘all over the place about how that representation should be managed’.

In one site, there was no VCSE sector representation on the HWB, and local government cuts to funding had led to there no longer being a staffed Council for Voluntary Service in the area. However, an assembly of third sector organisations had been established ’just from that passion really of wanting to try to work together’. This assembly received no funding but was run on the ‘goodwill’ of its members. At the instigation of the CCG, there was a partnership agreement between the assembly and the CCG. The interviewee observed that the local authority had ‘not really been communicative in the last couple of years’, although there was a level of engagement achieved through ‘the CCG effectively … speaking on behalf of the HWB’.

Two interviewees were less concerned about the lack of VCSE sector representation on the HWB. One spoke of the local authority making a deliberate decision not to widen membership beyond the statutory requirements, but of there being an ‘informal board’ where other stakeholders and partners could be represented. This informal board had two ‘voluntary and community sector’ representatives.

Finally, there was a VCSE sector interviewee who spoke of engaging directly with public health staff, rather than with the HWB, its other members, or with other parts of the local authority. They shared others’ views of the difficulty of a single person representing such a diverse sector, especially as the geographical area involved was one of the largest of all the sample sites. They observed that engagement and collaborations within the sector were challenging, and that that the voluntary sector was not ‘very cooperative and collaborative’ in the area. There were, therefore, marked differences in the extent of engagement across the local authority and the VCSE sector across the case study sites.

***3.8.4 Fragmentation across the commissioning system***

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

*Primary care commissioning*

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

 *So NHS England is responsible for the medical contracts for primary care, but CCGs also commission primary care services, and local authorities also commission from primary care contractors. And primary care contractors are confused about who commissions what for them, who pays for what. So sexual health services are commissioned by local authorities, and clinical commissioning groups commission through local enhanced services other things from primary care. We commission immunisation services from GPs. We do the out-of-hours GP provision. The standard medical contract is held by NHS England with them. So you’ve got three different commissioners, one poor GP, and they’re all thinking hold on a minute who do I talk to about what?*

The separation of commissioning responsibilities following the Health and Social Care Act had led to difficulties in keeping everyone informed and involved. An NHSE interviewee described a ‘fractured’ system, noting that commissioning oversight groups had been set up to address these issues:

*So I think it’s fractured so much sometimes that it’s not clear of the roles and responsibilities. Flu, for example, those sorts of things. We had a development session with all of the patches the other week, and got everybody to sit down in their system round the table, and it’s amazing how out of date some things are. ‘Oh I thought you’d do that, how do we do that these days?’ I think it’s had to, in some ways we’ve smashed some of these things to pieces that were quite simple, and tried to put them back together again now.*

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

Issues were raised in relation to liaison with practices over immunisation and vaccination: negotiations with independent contractors were described as less effective than the previous arrangements through the PCT. It was suggested that NHSE could do more to monitor and performance manage preventive activity being carried out through primary care. CCG interviewees also commented on fragmentation of commissioning and the importance of commissioners incentivising providers to work better together. A CCG interviewee noted:

*But actually for the patient... they see one system with lots of barriers in the way to accessing services. They don’t understand that GPs and health visitors are under different contracts; they just have an ill child who needs something*.

*Immunisation and vaccination for school age children*

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

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

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

*Health protection*

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

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

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

A public health consultant in another site commented in detail on the ‘parlous state’ of health protection:

*I feel it’s very fragmented, very unclear, very under capacity to deal with significant outbreaks for instance. I feel that there’s a huge loss of experienced staff who know how to deal with that, so recently we’ve had an infectious disease outbreak in our city, and whilst I wasn’t directly involved in it, my colleagues in my public health team were very involved in it and I know that they found it extremely difficult to be effective in the face of a public health crisis, because there were so many people involved with unclear roles and responsibilities.*

 *Data sharing*

A fourth area highlighted by interviewees was data sharing, described as a ‘minefield’ by one interviewee. Despite the importance of sharing patient/client/person data across sectors, data sharing had become more difficult. It was also pointed out that this was more the result of national guidance on technical information governance issues related to which data were shared and for what purpose, rather than the reforms. A DPH noted:

 *The Health and Social Care Information Centre completely fails to understand the importance of local public health departments accessing data. And almost every – and I think ONS is falling into the same trap now – I think almost everything that we hear about is well you can’t access that. And I don’t know how we do our work actually.*

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

A DPH noted:

*As director of public health I could get access to and have published in previous public health reports information about performance on immunisation at GP practice level.... . I can’t even see that information now. As the director of public health I am not allowed to see uptake of vaccination and immunisation information at practice level, even though I’m the director of public health, because NHS England said it’s confidential. It’s appalling. And I think if, you know, when the ring fence comes off I think we run the risk of removing some of those very important statutory functions that the director of public health has for the whole of the population.*

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

*As a commissioner I’m not allowed to see patient level identifiable, or patient level data, whereas as a PCT I was. And so actually it’s very hard to drive all this stuff so that, so the risk profiling tool technically we’re probably breaching the rules ... it’s a flaw of the legislation which they’ve known about since they wrote the legislation*, *and have promised repeatedly to just twiddle it and have never quite got round to writing the secondary legislation.*

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

While cross-directorate working and system-wide approaches were considered advantages of transferring public health responsibilities to local authorities, overall there was less emphasis on this aspect than on initiatives to facilitate closer working of public health staff within certain directorates and on the agenda for the integration of health and social care. The role of public health in influencing across this wider system in the context of the wider leadership role of local authorities is discussed in the following section.

## 3.9 The public health leadership role of local authorities

***3.9.1 Introduction***

The Public Health White Paper, *Healthy Lives, Healthy People* (Secretary of State for Health, 2010) stated that ‘Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors’ (p.51). Local leadership through local authorities was described as ‘at the heart’ of the new public health system, with the aim of embedding public health across local government.

Themes related to public health leadership are reflected throughout this report, both in relation to the leadership role of the DPH and in the context of support for the public health agenda across local authority directorates, as shaped by member priorities. A key issue is the extent to which a public health approach is embedded across a local authority and reflected in commitment to working across directorates and the wider system, as discussed in the previous section. Relevant aspects include the extent to which the HWB encompasses broader health issues, involvement of scrutiny committees in considering public health outcomes and the public health budget, the role of elected members and the extent to which health and health inequalities are routinely considered as part of decision-making.

This section explores some of the complexities that arise in developing the leadership role of local government in promoting health and addressing health inequalities. Six main themes are explored: transition to a leadership role within local government; hallmarks of successful public health leadership; working within democratic decision-making structures; the influence of the evidence base in priority-setting; trust and relationships; and the broader leadership responsibilities of local government.

***3.9.2*** ***Transition to local government leadership***

There were reports of very different experiences of the transition from the leadership model current within the NHS and that within local government. Generally, those who had worked closely with local government prior to the reforms found the transition smooth, even ‘seamless’. Reference was made to partnerships dedicating time and resources to redefining ‘how health and social care should interact’, or of public health being already embedded within local government, ‘so working together (was) not new and having a director of public health that spans both organisations (was) not new’. For those sites which had not established such relationships prior to the reforms, the experience was mixed. Members, local government officers, DsPH and CCG interviewees spoke of difficulties arising from cultural issues, such as differences in use of language, to more fundamental challenges such as Members not fully understanding public health nor their new roles and responsibilities and DsPH having difficulty adapting to an organisation where they were less autonomous. Further challenges arose from having to learn to work within local government committee structures, with one DPH commenting that this slowed down the decision-making process. However, members in some sites also showed frustration with DsPH not fully understanding these different decision-making structures when they took up their posts. Reference was made to a DPH having ‘some difficulty, in my opinion, getting to grips with the democratic process’.

The requirement for DsPH to produce an independent annual report in the public domain, for example, was considered by one interviewee to reflect ‘a privileged position’ in relation to ‘financial, legal and managerial’ controls on advice in local authorities. While some DPH reports were clearly being aligned to local authority priorities and interests (covering issues such as planning, the role of schools in promoting health, and the health of children and young people, to include looked after children) and interviewees in some sites commented on the reports being very well received by elected members, in other cases the value of the annual report was questioned, as reflected in this view from a HWB Chair:

 *I’m not sure what difference it makes that a public health director within a local authority needs to be making a statement on an annual basis. I don’t know what good it does or how much notice is taken of it.*

Some NHS interviewees continued to voice concerns about these transition issues. Local government interviewees, including DsPH, generally felt that these issues had either been resolved or that progress towards resolution was being made. The view of local government interviewees was that leadership of public health was best placed within local government, that public health had ‘come home’, and that the reforms would be beneficial for both the public health profession and for the public. However, challenges continued and were summed up by a DPH as follows:

 *I think it's making sure we've got that leadership, making sure that public health is valued and around the table is still one of those areas that we're working on. It's interesting. It's fascinating. And, I suppose ... it's going to remain challenging for some time.*

***3.9.3 Hallmarks of successful public health leadership in local authorities***

When asked to define hallmarks of successful public health leadership in local authorities there was considerable agreement among interviewees from all sectors, although some commented specifically on leadership of the public health profession, some on generic leadership characteristics and others on the leadership role of the local authority as a whole. Many interviewees spoke of collaborative leadership. This referred to an ability to lead across local authority internal boundaries, to lead across partner boundaries such as with CCGs and the VCSE sector, and across community boundaries. Collaborative leadership skills included being able to ‘spot the overlaps’, being able to build relationships, being able to influence, and finally being able to engage with the public. The outcome of collaborative leadership would be shared responsibility for achieving positive health and wellbeing, including sharing responsibility with communities and individuals. This was summed up by one interviewee as:

*trying to develop the community, and the community which can take the responsibility, and … take charge of their life and their neighbours.*

VCSE sector interviewees saw successful public health leadership as collaborative and achieved through ‘engagement with the public’. Some felt that successful leadership should also be visible, in order to:

*maintain the identity of public health amongst all the local authority services, ensuring that as system changes take place, public health remains a leading and recognised body in improving the wellbeing in the locality.*

However, as with statutory sector interviewees, others felt that visible leadership may not be necessary. One reflected:

*Does the general public know anything about what the health and wellbeing board does? And I think we’ve come to the conclusion that probably doesn’t, but does it matter as long as things are right out there?*

Some interviewees viewed charismatic leadership, built on an ability to communicate and inspire, as an important hallmark of success. Interviewees spoke of being able to ‘bring good messages’, of being ‘a passionate advocate for health inequalities … who has got a vision for the preventive agenda and can lead that work’. Much depended on the level of influence and negotiating skills of the DPH. A NHSE interviewee commented:

*So I think it comes down the strength of the director of public health, the visibility of the team and how the local authority have maintained that corporate director level post for the director of public health.*

Secondary hallmarks were results-based leadership, visible leadership, and publicly accountable leadership. In many ways, these hallmarks were tied in with that of collaborative leadership. Interviewees spoke of ‘having some wins’ and being able to ‘bring good messages’ in order to motivate and engage potential partners. Possibly because of the recent changes, interviewees spoke of the need to ‘maintain the identity of public health’, the importance of ‘championing public health both internally and to the wider community’ and of achieving political credibility. Members were particularly conscious of their responsibility to their constituents and so needing to account to them in order to engage their support. One HWB Chair described successful public health leadership as ‘taking people with you … to take decisions which can impact on their long-term life prospects’. Another HWB Chair spoke of ‘failing our population’ if this did not happen.

The least mentioned hallmarks of successful public health leadership were leadership arising from technical knowledge, or ‘having a good understanding of the evidence’ and command and control leadership, described by one CE as being able to ‘force people to be cooperative’. However, although these were the hallmarks which featured least in the list that interviewees believed public health leaders should aspire to achieve, they were frequently discussed when describing the leadership currently exhibited.

Interviewees also discussed implications of a successful public health leadership role. For one NHSE interviewee, for example, this included a strategic leadership role for DsPH very much in line with the original intention of the reforms, noting:

 *I think the hallmarks are that the director of public health is recognised as a leader within the local authority, so they are a corporate director. I think that’s recognising they are on an equal par with all the other directors. And I think they should be judged on the public health outcomes that that person is accountable for, and their team has to deliver for that population.*

Others noted the importance for public health leaders of being able to influence and ‘bend’ mainstream funding and of showing systems leadership. The most important defining characteristic of leadership of local authorities, however, was the extent to which the agenda was embedded across the local authority, as expressed by one CE:

 *Myself as chief exec, I’ve got an executive director team, I’ve got service directors who are comfortable and fully appreciate and engage on the broader Public Health Outcomes Agenda, because they see it’s at the heart of what they’re about, the vast majority of them are about public health outcomes ultimately. So, that leadership also goes right to the heart of the council, the leader of the council chairs the health and wellbeing board and he’s passionate about looking right across every portfolio about their contribution to positive outcomes, positive health outcomes, etc.*

Other interviewees cited the importance of understanding across local government the impact of different influences on health. An Executive Director noted:

*I think they have to have demonstrated they understand what the public health outcomes are that we are trying to deliver. I think they have to understand ... the different component parts that matter in terms of improving people's public health. And that's in terms of people's behavioural change and the place elements, the environment, so to demonstrate both of those. To recognise that actually public health, a bit like safeguarding, is everybody's business. So whatever part you work within the authority, you need to think about public health. Those are the key things, I think.*

Part of this was successful communication with the public over health-related issues as well as over the new responsibilities of the local authority. Interviewees commented on the importance of a focus on citizens and their wellbeing, of changing public attitudes towards health and illness, and of all local authority employees ‘owning’ the public health agenda. A sign of effective public health leadership would be that:

 *the public health question comes up, or the health question comes up in every discussion. That's when I'd know it was really integrated and in there. But, you know, when they're discussing housing, they would immediately talk health. When they're discussing education, they would immediately talk health. But it would be much more integrated. At the moment I don't think they've quite broken that barrier.*

While embedding a public health ethos across the local authority was recognised as taking time, the status of a local authority as a ‘public health organisation’ needed to be recognised and reflected throughout its directorates. There were different organisational models for this, but where, for example, a lifecourse model was embedded in the way that local authority services were organised, and where wider determinants of health were incorporated in each phase, the potential for integrating public health actions across the local authority was heightened.

***3.9.4 Working within democratic decision-making structures: collaborative and hierarchical ways of working***

Although members hold ultimate decision-making power, there were examples of sites where the DPH had delegated authority for making most decisions, and of sites where there was positive engagement between members and DsPH, with one DPH speaking of how there was a ‘focus on briefing the councillors’ and how they now ‘work with the councillors to shape how the (public health) function works’. The position of the DPH within the local government hierarchy was also not necessarily a barrier to positive, collaborative leadership. One DPH who did not report to the CE described a working environment where people had ample opportunity to meet and speak informally with the CE and members, concluding ‘If I want to go and talk to the Leader, I can go and talk to the Leader’. In another, while an Executive Director held the commissioning budget the DPH emphasised that ‘because she's so collaborative and always discusses with me what should be done with it, I welcome that because I don't have to do all the budget management, but I know I've got the influence and the sign-off, so we work very well together’.

In a number of sites, public health staff were dispersed across local authority directorates, but this was also not necessarily a barrier to leadership, either of the public health agenda or of public health staff continuing their professional development. One DPH spoke of being:

*a little freed up to work more cross-council so more under wider determinants. Having said that, obviously, we are continuing to provide that professional direction for anybody that has got public health skills, and so they still need a lot of direction in terms of their work. So although it's not line-management, there's a lot of professional direction that continues.*

A CE reiterated that it was ‘the understanding of the whole council that makes public health really work. If you keep it in a box separated out from your organisation ... you will marginalise it and you will have less impact’.

However, there were examples of sites where location of the DPH within a hierarchical structure was considered of key importance. A number of interviewees stated that the decision to place the DPH as directly reporting to the CE had been made deliberately to ensure and protect the leadership status and authority of the role. One CE spoke of wanting:

*public health to be completely integrated into the council, influencing every part of the council with a key line of sight to me and elected members.*

This suggests a different leadership culture from those sites where the DPH did not report to the CE but nonetheless was integrated, could influence and had direct contact with the CE, directors and members. A DPH in another site referred to having been ‘knocked down a peg in the hierarchy and this is a very hierarchical organisation’, and being expected to:

*go back and check every time, often on a weekly roundup you tell the elected member what you're doing. Is that all right, boss?*

In this site, the DPH reported being expected to advise and negotiate with the lead member before being authorised to speak to any other member, and of significant decisions being made about public health resources without their involvement.

The change in leadership status of DsPH was acknowledged by interviewees, including members, other local government officers and interviewees from Healthwatch and the VCSE sector. There was reflection that leadership within local government, regardless of the level of collaboration, retained an element of command and control because ultimate power was held by members, and so any decision to share this power was their gift. Decisions to support public health may not always be popular, and one DPH referred to being:

*a lone voice in the wilderness … if you make yourself too unpopular then you completely cease to be heard. And then you’ve lost any opportunity.*

However, others spoke of making particular efforts to communicate with and engage members on their terms, with one reflecting that ‘part of my leadership role is to help them with their leadership role’. Whilst a NHSE interviewee had observed that not all members had a ‘good grounding in public health issues’, many DsPH found members genuinely wished to fulfil their leadership role successfully, and believed that this could be achieved in time. A number spoke of welcoming their new way of working and this collaborative leadership role providing opportunities to challenge national government policies, to have ‘more local autonomy’, and to benefit from members ‘voting local authority money over’ to support and protect services which might otherwise be cut.

This paradigm of member decision-making power was also reflected in approaches to the HWB in case study sites. Many interviewees made reference to the role of the HWB being unclear and of it having no decision-making power. Some interviewees also made reference to the HWB being unrepresentative and unable to engage with the populations it served. However, there were examples of sites where the HWB was integral to public health leadership. In one site, the HWB Chair was shared between the local authority and CCG, so that it:

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

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

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

The Chair went on to speak of the HWB having:

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

This was markedly different from some sites where decisions on HWB membership were made by the local authority, sometimes without prior consultation. HWBs were not always consulted or informed about public health-related decisions. Positively, although there were examp*l*es of HWBs deliberately not including VCSE sector representatives, there were examples of sites where they were included and the VCSE sector interviewees believed that, as a result, they and the wider community were able to participate in and influence leadership of the public health agenda.

***3.9.5*** ***Evidence and decision-making in a political context***

Many interviewees welcomed the expertise in data analysis and evidence brought by public health teams. One CE commented:

*And I think what is really good about public health is that they have evidence-based approaches - and {the DPH} throws it down our throats all the time but she’s right to do it - is that money shouldn’t be spent unless it’s very clear that the outcomes will be delivered. And so I like that approach.*

However, even in sites where there was a strong culture of collaborative leadership, there was discussion over the balance of ‘evidence-based leadership’ and leadership arising from a political mandate.

Although DsPH may have developed collaborative leadership skills, building alliances with members, officers and other stakeholders, and communicating effectively, this did not necessarily lead to members using evidence as the primary basis for decision-making. One director described public health adhering to a leadership culture based on a:

*clinical mind-set which says ‘this is the evidence, that’s what you should do’.... . But it doesn’t recognise that other people see the world in a different way, and may not think that’s important, even though the evidence says you should do it.*

A DPH commented in the same vein:

 *I think one of the problems that we’ve got with local authorities and elected members in particular is that they do not have a very high regard for evidence. Whether that’s evidence of need, which they think they understand because they think they’ve been elected from a community and they know that community, or evidence of what is effective, because that’s just not something that crosses their radar most of the time.*

This implied a need to broaden public health evidence, as reflected in the established evidence base for public health interventions, in order to reflect the experience of elected members and ‘anecdotal, qualitative-type evidence that councils collect’. A ‘compromise’ needed to be reached across the two approaches. Members valued officers ‘targeting increasingly scarce resources at the places that really will make a difference to them politically’ and it was important to adopt a corporate approach.

Some DsPH felt that there was a lack of evidence-based leadership because local government did not respect the skills and resources that public health professionals offered. One DPH reflected that leadership authority in local government arose from having ‘teams of 100 people you were directing’. Another spoke of a decision to place some selected public health services under the leadership of another directorate, rather than awarding leadership to someone with:

*five years training in public health techniques …. behavioural change and working with communities and has passed exams in it and remains accredited and supervised in it.*

However, another DPH felt that:

*the worst thing anyone could do as a director of public health is move into a council and be all the expert, because that is not how councils operate.*

This DPH also believed that there was ‘a wealth of talent of people within local government who would make excellent directors of public health’. Rather than viewing local government’s politically driven leadership as a challenge, they believed the challenge to be attracting existing local government officers to train as public health specialists so that they could be deployed back into local government. In another site, it was suggested that over the longer term, public health specialists would be replaced by a larger pool of staff with broader skills.

Interviewees outwith local government were particularly concerned that decision-making could be politically driven rather than evidence-based. A VCSE sector interviewee commented that:

*they couldn't, for example, I don’t know, advertise sexual health services for young people without the express acknowledgement and support of the elected members whose wards that was going to happen in. And I think that was a massive shock for public health staff, who were used to thinking ‘well as long as I'm meeting my objectives that's the point’, to actually finding that there was this kind of political element inside it as well.*

 Nevertheless, most interviewees felt that that politically driven decision-making of this kind was not widespread in their experience, with one commenting that ‘we are very fortunate, we’ve got a sensible council’.

There were other challenges associated with leadership based on political mandate. Difficulties associated with the election cycle were acknowledged by most interviewees, particularly the tendency to concentrate on short-term rather than long-term outcomes and the extent to which this was incompatible with public health planning. Some district councillors were described as more ‘parochial’ in their outlook, concerned with their individual wards rather than with the needs of the wider population. An interviewee commented:

 *And my experience is that, intrinsically, a lot of them are very parochial. They’re district councillors from x or x or wherever and they work on anecdote and they work on very localised experience. And I think that it's hard for some of them to actually - some of them can, clearly, but it's hard for some of them, in my experience, to get into a strategic discussion, or more strategic discussion.*

Other interviewees were critical of the cabinet system within local government, believing that it placed too much power with a small number of members and reduced opportunities for other members to influence decision-making.

Nonetheless, these challenges were not necessarily greater than those posed by centrally controlled leadership, which generated criticism for mandating services which did not always reflect local need, or for promoting investment in interventions (such as on childhood obesity) where the evidence of efficacy was limited. Members and local government officers, including most DsPH, appreciated the legitimacy which a political mandate gave to public health leadership but there were challenges in incorporating evidence-based leadership as part of the DPH role.

***3.9.6*** ***The importance of trust and relationships***

Many interviewees from sites where leadership was mainly collaborative spoke of the importance of trust between partners. Examples included trust between local authority directors, who spoke of sharing resources and even undertaking additional work to help achieve others’ priorities, and trust between members and DsPH, where decision-making authority was delegated. Examples also included VCSE sector interviewees, who spoke of being trusted partners in the pre-tender process and so helping to design solutions, or of being trusted to undertake pilot projects with no clear outcomes and so helping to lead innovation.

In contrast, other interviewees spoke of relationships which were not based on trust. One site was in the process of introducing service level agreements, specifying targets and outcomes expected of other directors given responsibility for part of the public health grant in order to prevent public health spend from being raided. There were a number of sites where the VCSE sector was excluded from the HWB and from the pre-tender process, which resulted in the sector being excluded from all collaborations. References were made by both some members and some local government officers about the VCSE sector being overly expensive, not engaged with local communities and adversarial; all suggesting that the VCSE sector was not viewed as a trusted partner.

However, there did not appear to be a clear link between an authority’s leadership and the decision to formulate agreements on contracts rather than on trust. One site, which showed a high level of collaborative leadership both before and since the public health reforms, had a system of service level agreements which were intended to embed a public health ethos across directorates and were widely accepted. Some VCSE sector interviewees felt that the more rigorous commissioning arrangements within local government promoted trust, engagement and participation. A number of DsPH had referred to the bureaucracy of local government, but possibly these examples illustrate both that trust cannot be contained within a written contract, and that such contracts can sometimes lead to greater transparency and openness, which actually generate trust. Despite the increased bureaucracy, local government culture might support an increase in trust between partners, an increase in collaborative leadership and so improved outcomes.

As previously discussed, the public health reforms had led to reorganisation which had a disruptive and sometimes damaging effect on networks and relationships. Regardless of the structures and processes adopted by individual areas, there was a level to which successful leadership was dependent on trust between individuals. One VCSE sector interviewee concluded that ultimately this was ‘down to individuals who want to make it work’.

***3.9.7*** ***Being more than leaders of public health***

The Health and Social Care Act 2012 gave leadership responsibility for public health to local government. However, local government has statutory responsibilities for many other areas of public life which influence the context in which priorities are agreed. Competing priorities were discussed by many interviewees. Commonly mentioned was the competition for children’s services between public health priorities on childhood obesity and priorities on educational achievement; competition between public health priorities on healthy eating and priorities on town centre economic development; and competition between priorities on healthy lifestyles and priorities on wider determinants of health, such housing and transport development.

Despite the commitment which members and officers exhibited for fulfilling their public health leadership role, one member did observe that public health was ‘quite a way down the hierarchy’ of local government concerns, partly because it represented a very small part of the local authority’s total budget. Although interviewees were able to articulate thoughts on the main public health challenges that, as leaders, they need to address, they did not say how this responsibility would be fulfilled given a host of other local government responsibilities.

# 4. Strengths and limitations of the study

Strengths of the study include the participation of 10 local authorities which met the selection criteria and the engagement of 90 stakeholders reflecting key roles. Authorities were drawn from all regions in England, apart from the North East, included unitary and multi-district authorities, and varied in terms of size of population, deprivation levels, ethnicity profile, rurality and political control. Most worked with a single CCG, but four had links to multiple CCGs. While the number of case study sites is small – 10 out of a possible 152 – fulfilling our selection criteria ensured that we reflected a wide range, thereby increasing the potential relevance of our findings. Moreover, most local authorities are facing similar financial challenges, pressures to do ‘more with less’ and to pursue greater integration. The final report will draw together qualitative and quantitative elements of the study, providing a wider context for the issues raised in this report.

These sites provided rich qualitative data for the research questions related to each of the three workstreams, as well as to overarching themes: addressing health inequalities; innovation; and public involvement. The study demonstrates how approaches to health inequalities are shifting to reflect local authority priorities and illustrates ways in which preventive services are being recommissioned according to a social model, aligned with local authority services and priorities and integrated with broader changes across health and social care. The study also documents changes in the role of the public health profession and in how preventive services and evidence are being understood and prioritised in a context of local democratic accountability.

There are, however, a number of limitations. First of all, local authorities are inevitably varied and distinctive and while this variety can be interpreted as a strength, reflecting local flexibility and innovation it limits the extent to which we can generalise from our findings. Ethical requirements to preserve anonymity also work against detailed contextual information or the highlighting of good practice.

Moreover, local authorities differed in their involvement with (and commitment to) public health priorities prior to 2013 and this limits the extent to which it is possible to identify the distinct contribution of the public health reforms. The organisational and accountability arrangements and responsibilities of public health staff also vary by authority and the transition has been managed in different ways.

This study was designed to take an overview and not to assess the effectiveness of specific preventive initiatives or their sustainability. However, these are important questions, especially given the context of public sector reform in which public health teams operate and the wide range of community-based initiatives being established in order to manage demand.

Finally, the concurrent financial restrictions in local authorities, in conjunction with the in-year cuts to the public health grant, were seen as limiting the potential of the reforms.

# 5. Discussion

There was great variation across the ten case study sites and there is likely to be even greater variation across England. This inevitably limits the extent to which we can generalise from our findings. However, the extent of variation is itself indicative of the many different ways in which prevention and public health are being defined, the public health contribution interpreted and the reforms implemented. This is, in part, a function of the inevitable differences between democratically elected local authorities, different histories of local commitment to the public health agenda and to collaboration prior to the reforms, and differences in how the transition was managed and working relationships established.

As first phase interviews were completed in May 2016, three years after the implementation of the reforms, it is not surprising that the policy context had changed. In some authorities, devolution was being discussed along with the role of public health staff in new arrangements. Following the reorganisation of NHSE, these representatives no longer routinely attended HWBs, providing instead a ‘helicopter view’, intervening where there were poor standards and with the CCG seen as the local system leader for the NHS. From October 2015, health visiting became a local authority responsibility allowing the integration of children’s services from 0-19.

More fundamentally, it became apparent that some of the research questions reflected in the interview schedules were perceived as less relevant by interviewees than had been the case at the time of the initial scoping phase of the project. Commissioning public health services and the reporting categories of the public health budget were increasingly discussed in relation to local authority commissioning priorities and reporting categories (notwithstanding reporting arrangements to the Department for Communities and Local Government). Where services were not mandatory, such as smoking cessation services, these services were at risk (albeit with some exceptions). Sexual health services, as a mandatory function, were more protected, but this was less the case for NHS Health Checks. In many sites, the most important contributions of public health staff, apart from intelligence and evidence input, were described as persuasion, ‘telling a good story’ and networking across local authority directorates and members. The commissioning role of public health was less profiled, often included within a central commissioning facility and conversations were less about a public health commissioning system than a commissioning system with public health included in it. There were exceptions, however, where DsPH not only largely controlled the public health budget, but also had responsibility for additional services.

Most interviewees considered that advantages of the reforms outweighed any disadvantages given the importance of wider determinants of health, although the potential benefits of the shift in responsibility had been limited by concurrent financial restrictions. There were benefits of skills in data analysis, a public health dimension to needs assessment and through exerting influence across directorates. There were also benefits arising from a greater understanding of public health among elected members. Some DsPH saw an increased influence across planning and licensing decisions and synergy across public health and local authority priorities. There were exceptions, mainly among some elected members, NHSE interviewees and CCG interviewees, with comments over the fragmentation of commissioning, the separation and potential longer term isolation from the NHS and a weakening of relationships. For some CCGs, public health involvement was limited, while for others, public health consultants were members of the CCG governing body and there were examples of joint commissioning of preventive services. As they discussed public health contributions, however, Executive Directors particularly emphasised intelligence, data and needs assessment, rather than commissioning responsibilities or wider influence. While this was less the case for sites with a long-standing public health ethos, there was a noticeable mismatch between the main advantages of the reforms in theory and how they were described in practice.

Engagement with communities and co-design of services were considered to be well developed in local authorities and independent of the transfer of public health responsibilities. There were a few examples of co-design influencing preventive services as they were recommissioned, but this was an area that could be further developed in line with the new public health responsibilities of councils.

The different ways in which the public health budget had been used, combined with various permutations of how the budget had been aligned to local authority spend provides an insight into how public health and preventive measures were being conceptualised in practice across the sites. The study raises wider questions over definitions of public health and the over the role and identity of the public health profession.

*Definitions of public health, a ‘public health authority’ and ‘preventive’ measures*

While it was common for CEs, for example, to describe their authority as a ‘public health authority’, practical implications of this or the extent to which it was systematically reflected in local authority decision-making processes differed across sites. As almost council activities could be linked to public health outcomes, being a public health organisation could simply express a tautology, reflecting the status quo. In other cases, a public health ethos was reflected through organisational arrangements, in cross-directorate working and its importance was expressed by all interviewees in a site, including elected members. In either case, the separate and distinct contribution of public health teams and a consensus over where input was most needed could be difficult to identify. The report has summarised some of the initiatives that have been established but the drive to reduce demand on statutory services was inevitably a major driver across all sites.

Against this backdrop, understandings of public health differed as did approaches to health inequalities, as discussed in section 3.3. Confusion over what public health involved was expressed by elected members in some sites and views over what public health entailed varied among both officers and members. There was, for example, a view that local authority responsibilities for those who were unable to take responsibility themselves (children or vulnerable groups) should take priority over influencing lifestyle choices. Notions of accountability and individual responsibility had clear implications for the direction and configuration of certain public health services, how the public health budget was to be spent and how health inequalities were addressed and identified. The focus was more often on groups most likely to suffer from inequalities over the longer term (such as children identified as not ready for school) rather than on evidence on interventions likely to lead to reductions in premature mortality over the shorter term, the predominant emphasis in the former PCTs. The shift from universal and population-based services to more targeted approaches was evident, although the focus of the targets varied (geographical areas, client groups, particular vulnerable groups).

There were also concerns over the ‘geologic timescales’ for influencing longer-term health outcomes, as opposed to the immediate demands of statutory services and the priorities of elected members (including re-election). The public health budget was often rebadged to prevent cuts in services which had a clear impact on public health, such as children’s centres. However, action on social determinants of health, with which local authorities identified (and which was seen as a major advantage of the reforms) is also long term in its effects. Evidence-based lifestyle interventions, such as smoking cessation, were less favoured by some authorities. In response to this trend, some interviewees suggested that such services might need to be protected through a revision of the mandatory functions or by the NHS taking back responsibility for some preventive services.

 An element of ambiguity was evident over how key terms, such as ‘wellbeing’ or ‘wellness services’ were interpreted. For example, these could refer to services designed to prevent hospital admission, whereas integrated ‘health and wellbeing services’ could refer to: (1) health and social care services; (2) integrated lifestyle services; (3) a development of the latter, where action on social determinants of lifestyle choices was integrated with lifestyle services.

For preventive measures, the key question was ‘prevention of what?’. Emphasis could be placed on preventing pressures on various ‘front doors’- of hospitals, social care and children’s care homes - focusing on needs of the most vulnerable and on particular client groups and preventing or delaying the need for statutory services.

While all sites had preserved lifestyle services to some extent (often influenced by the legacy of contracts developed while public health was still located in the NHS) there was evidence of reorientation, greater targeting, changes in providers and in contract specification. As intended by the reforms, there was also greater alignment with other local authority services, such as leisure services (some DsPH held the budget for leisure services) and a commitment to embed prevention across the activities of other directorates - integration with children’s services being a good example. The transfer of services for under 5s in October 2015, which followed the transfer of school nursing services in the 2013 reforms, provided the opportunity not only to integrate public health services for children but also to influence other activities of children’s directorates and help target services to those most in need. There were few examples of new and additional lifestyle services being commissioned although recommissioned services could include a greater emphasis on co-design, more rigorous procurement processes and better alignment to the authority’s priorities. One example of the latter was for wellbeing of children and families to be considered as part of drug and alcohol services. The lifecourse approach adopted by the Marmot Review (2010) and reflected in the Public Health White Paper (Secretary of State for Health, 2010) provided a model for integrating a preventive element across different aspects of council activity, with early intervention and needs of the most vulnerable children being prioritised. In the context of the needs of vulnerable groups, such as looked after children, the deployment of funds for preventing smoking often receded in importance for directors of children’s services, as well as for elected members.

In the same way, the new hubs for integrated care could include more preventive initiatives, although their development was more closely linked to the integration agenda than the transfer of public health responsibilities.

Different approaches to evidence within a local authority context have been identified in previous research (Lorenc et al., 2014; Hunter et al., 2016; Marks et al., 2016). Our report found clear tensions over what constituted evidence, its role in decision-making within a context of democratic accountability and how evidence should be presented to influence decision-making. This was contrasted with the role of evidence as presented by professionals within the NHS. Scepticism over the level and type of evidence needed to develop initiatives was expressed: elected members felt they understood the needs of their communities and were elected to reflect the priorities of these communities. These needs and priorities might not coincide with priorities implied by evidence on the effectiveness of public health interventions, as presented by a public health team. The evidence base, rigidly defined, could hamper innovation, the ability to fund ideas coming up from communities and was often long-term in its effects, which could jar with immediate and short-term priorities and might not feed into factors that could ensure election. While the evidence and data contributions of public health teams were recognised, there was tension over the role of evidence in decision-making. However, there were also examples of how these issues were being addressed in practice: while there was commonly support for elected members through ‘development’ days, focusing on specific topics, some sites had invested a great deal of public health time in supporting elected members. One site had held an extensive programme of ward-based meetings, discussing health profiles of wards and the role of members. A grounded approach to evidence may take time to become fully embedded. The emphasis on reduction of premature mortality through addressing inequalities in health, and the contributory lifestyle factors, a common emphasis in the former PCTs, was less evident.

*Integration, corporacy and professional identity*

The nature and extent of integration of public health into local authorities was a key issue. DsPH were statutory members of HWBs and played a key role in the JSNA and the JHWS. Only five DsPH in the study reported directly to the CE. Even where they were not directly reporting to the CE, DsPH could form part of the senior management team of the local authority. However, a key issue was how far they were integrated or could influence areas of the authority with which they were not directly involved and their contacts with elected members outside the portfolios they were directly connected with. While being part of a stand-alone directorate could give credibility, greater influence could be exerted being part of another directorate with isolation less of a risk. However, departmental integration could potentially lead to a loss of integrity for the profession of public health, weaken a sense of identity and the professional skill set. Concerns over the loss of a population perspective were expressed by some DsPH. There was, therefore, a trade-off between more central control but greater autonomy in decision-making, as in the NHS, and greater local flexibility but often a reduced status within the local authority. While the cross-cutting nature of public health was a challenge for the profession, it was also a challenge for the local authority. Issues could also be brought to different scrutiny committees, for example, which added further complexity, especially in large or multi-district authorities.

Many interviewees recognised that transferring public health to the local authority had resulted in ‘culture shock’, loss of staff and sometimes a lack of political credibility for many public health professionals, although this was not necessarily the case where joint working and a shared public health ethos were well-established and where there was continuity in relationships, including with the NHS. However, the effects of cuts, shifting roles and influence across the system was articulated by one DPH as being a ‘lone voice’ when it came to leadership of the public health system. In other sites, the public health team exerted little direct control over commissioning and was seen more as a public health intelligence resource for the local authority. Public health teams were perceived to be somewhat distant in some sites, and attempts were being made to integrate them within the corporate structure of the local authority.

These ambiguities led some interviewees to raise questions over what constituted the core tasks of public health. CEs in two sites (one urban and one rural) used theological terms in their discussion of public health - it was seen as ‘heretical’ if what was perceived as public health orthodoxy was challenged, and they emphasised the need for public health professionals to ground themselves in the local population and in local priorities. Of particular importance in a local authority context was evidence for improved outcomes and if this was not possible, it could further undermine the profession. Reflecting wider concerns with showing return on investment, it was emphasised that the economic arguments for prevention needed to be reinforced.

However, it was considered that as a new generation entered public health all this could change and that training should take account of the new context. Some interviewees suggested that local authority employees should be trained in public health skills and that a career pathway should be built in to local government and aligned to local opportunities for formal public health training. Some interviewees considered that the long-term effects on the public health profession and the public health function needed to be more carefully considered and that the next few years would be critical for public health to demonstrate its effectiveness within a local authority context. Executive Directors in local authorities made the connection between the need to redefine and transform the relationship between the individual and the state, reducing demand for care, encouraging communities to help themselves and creating a less ‘dependent’ culture. This was reflected in authorities under different political control and while this was often linked to lack of choice in a context of austerity, the link was also made with the benefits of empowerment and developing community assets. The importance of the public health contribution to wider public sector reform was stressed.

*In conclusion*

While first phase fieldwork confirms the view that the public health reforms were largely viewed as advantageous, identifying impact is made more complex due to three main factors. First is the extent of historical joint working and therefore the extent to which the reforms constituted a change, i.e. identifying the ‘added value’. This was particularly the case in areas with stable and long-standing joint working, community development approaches through a public health team, joint commitments to addressing health inequalities and where local authorities had already developed an identity as a ‘public health authority’, with a commitment to preserving this ethos as far as possible, despite austerity. Interviewees pointed out that many relevant activities were independent of the reforms - they were more about the priorities of a particular local authority and of the former PCTs. Second were concurrent and continuing cuts to local authority budgets, combined with an unexpected in year cut to the public health budget (2015-16). The fact that the timing of the transfer coincided with austerity was recognised as hindering potential impact - a factor that has been widely recognised and also reflected in previous reports of this project. Third is the integration of public health within operational and management structures of the local authority. To the extent that public health is fully integrated, its separate contribution becomes difficult to identify. As discussed earlier, where the public health budget is a local authority budget, public health teams are dispersed across relevant directorates and integrated commissioning and information resources are in place, the ‘added public health value’ of the transfer can be difficult to assess. In one of our sites, a service director asked the question:

*Where have they seen the best of the advantages you get from integrating public health into local government? ….there have to be some councils where actually it's worked in a really good way and they've been able to integrate services better, perhaps have that constructive challenge around the kind of political and the clinical bit. So, for me, it would be where do you look for those examples of political leadership?*

This study illustrated ways in which a social perspective was being integrated into traditional preventive services, a public health perspective was included in local authority services and political commitment to mainstreaming a public health agenda was demonstrated across local authority directorates. It showed that while all these aspects could be demonstrated, they were implemented to varying extents across the sites. We hope that the analysis of interviews carried out in the first phase of fieldwork illustrates how authorities are exercising their leadership role, as well as the current barriers that they face.

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# Appendices

## Appendix A: Interview schedule

1. In this context, it should be noted that a combination of disparate responsibilities is common in local authorities given the trend to combine responsibilities under fewer directorates. [↑](#footnote-ref-1)
2. Evaluating the leadership role of Health and Wellbeing Boards as drivers of health improvement and integrated care across England <https://www.dur.ac.uk/public.health/projects/current/prphwbs/> [↑](#footnote-ref-2)