Key points:

- Our research suggests that overall the transition of public health from Primary Care Trusts to local authorities went well. However, public health staff had to spend considerable time embedding themselves within local government, having to learn new organisational processes and procedures and adapting to a new culture.

- Respondents in local authorities (LAs) were generally positive about the move and that political support for public health goals is important. Most Councillor respondents were positive and supportive.

- Concern has been expressed about the structural position of public health teams and the Director of Public Health (DPH) within LAs and the continuing re-organisation of local authority functions often resulting in public health being part of a much larger directorate.

- Public health staff were generally positive about their opportunity to influence local strategic direction via the Health and Wellbeing Board, internal cross departmental structures etc.

- Local variation is enormous with two tier council areas facing more complex arrangements given the need to engage with District Councils.

- Our latest survey (September 2015) found that many authorities are expecting cuts to the public health budget beyond those being imposed by central government.

- The new system of public health (PH) is perceived as being more complex and fragmented than that which existed prior to 2013.

- There appears to have been a shift in the type and seniority of staff involved in PH. We found an increase in business managers/commissioning staff and a reduction in specialist PH staff. There are concerns that the move to LAs will encourage less people to choose PH as a career and that there is a perception that there are less qualified PH practitioners in LAs now. There was a perception that there is less scope within LAs for PH professionals to expand their careers.

- Our research suggests that links with Clinical Commissioning Groups (CCGs) are variable but that generally specialist PH support for CCGs is poor.
1. **Policy Research Unit in Commissioning and the Healthcare System**

1.1 The Policy Research Unit in Commissioning and the Healthcare System (PRUComm) is one of a number of Policy Research Units that are funded by the Department of Health. It was established in 2011 to develop a programme of research on commissioning and health systems to support the Department of Health’s policy development and analysis functions. PRUComm investigates how health services commissioning ‘works’, both as an organisational process, and as an instrument to secure policy objectives such as improved services, greater equality of access, greater responsiveness to patients, and improved effectiveness. The Unit provides high quality research evidence to the Department of Health, NHS England and local NHS organisations. All our publications are available from our website ([http://www.prucomm.ac.uk/](http://www.prucomm.ac.uk/)).

1.2 We support the Department of Health to manage the challenges associated with developing commissioning for health and wellbeing. Our key objectives are to:

- Develop high quality research programmes that support healthcare commissioners and policy makers
- Provide a national resource, holding evidence and research on commissioning
- Bring together academics who are nationally and internationally regarded as experts in health services, organisational and commissioning research with those responsible for making and implementing policy in order to foster relationships and exchange information.

2. **Research on the public health system since 2013**

2.1 In 2013 the Policy Research Unit (PRUComm) was commissioned by the Department of Health to undertake research following the transfer of public health (PH) responsibilities from NHS Primary Care Trusts to Local Authorities (LAs). The PHOENIX project is examining the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public’s health. So far this research has included: a review and analysis of evidence submitted to the Communities and Local Government (CLG) Select Committee; an exploration of the development of PH in a sample of LAs; surveys in 2014 and 2015 of Directors of Public Health (DsPH) and Councillors with a lead health responsibility; and in-depth interviews with key informants at regional and national level. The research team are currently preparing a final report.

2.2 As part of our research we undertook an analysis of the 26 expert witness presentations regarding the reforms made to the CLG Select Committee. These individuals represented a variety of stakeholders, including PH organisations, the NHS, Local Government and the Department of Health. We also analysed the 40 written
submissions to their inquiry to identify key themes and concerns.

2.3 Several challenges were identified in our report relating to the implementation of the reforms. With these, there was a tendency towards division between the opinions of the public health workforce and those of local authority and Government representatives. Three key contentious issues can be summarised as follows:

- Localism versus national / regional priorities
- Integration versus ring-fencing
- Autonomy versus accountability

2.4 Concerns raised by witnesses and in the written evidence highlighted the different perspectives about what localism would mean and the need to develop accountability to local communities. Concern was also expressed about how public health budgets would be used – especially at a time when local authority budgets are under significant pressure. They also identified that PH staff would have to adjust from having a primarily clinical focus to working in what may be an overtly political sphere subject to changing priorities and the electoral cycle.

2.5 The first phase of our research on the new public health system involved a number of scoping interviews with key national and local stakeholders during 2013. We identified a number of important themes which we explored during this phase. As reported in our first interim report some key points related to three themes - governance, relationships and new ways of working. These themes continue to emerge in later phases of our research.

2.6 The second phase of the research in 2014 involved in-depth case study research in five local authority areas and two annual surveys of DsPH and councillors with a lead responsibility for health (July/August 2014 and September 2015). The interim findings of this phase of the research are published in two reports presenting overall findings with a separate fuller analysis of the first survey results. Findings from the first DsPH survey are also reported in a paper in the Journal of Public Health.

2.7 Organisational arrangements for PH in LAs are complex, and still evolving. In two-tier areas, the important role of district councils is recognised but has yet to be fully developed. There are a range of organisational arrangements between authorities including joint appointment of DsPH, shared PH teams, formal inter-authority collaborations and agency arrangements where one LA acted on behalf of another. These are not all discrete developments with some authorities displaying a number of different relationships. In addition to these inter-authority relationships, there are a
range of differing relationships with CCGs, service providers and regional and national public health and NHS agencies.

2.8 Our findings highlight the fragmentation of the new system, and the continued state of change as structures and processes evolve, and as roles and relationships are developed (see for example Mansfield 2013, Willmott et al 2015). This is occurring in the context of wider change, as LAs (and others) continue to adapt to deal with financial pressures. PH teams in LAs have faced profound changes, having gone from a position of ‘expert voice’ to a position where they must defend their opinions and activities in the context of competing demands and severely restricted resources. PH staff needed to acquire new skills, and needed to seek new ‘allies’ to thrive in the new environment.

2.9 In addition to fragmentation, our case study findings pointed to a sub-optimal system design (with sometimes negative feedback and unintended consequences) with some tensions related to the resulting lack of role clarity which have, in some cases, influenced relationship building amongst system actors. Governance of such an emerging, fragmented system is a huge challenge.

2.10 Despite the turbulence of the reforms, both PH leaders and elected members were positive about the way PH teams had transferred and become embedded in LAs. The organisational arrangements for public health are varied, with the majority (52%) being within a larger directorate, such as adult services, and some remaining as a distinct PH directorate (26%). In our latest survey of DsPH (September 2015) nearly half of the respondents reported that they expected further reorganisation of PH teams.

2.11 Where the PH team is not held in a separate directorate, there might be a more immediate chance to be embedded into local government. However, where a distinct PH directorate is formed, PH professionals might have a greater degree of autonomy, and the DPH usually has a direct reporting line to the Chief Executive facilitating working across directorates.

2.12 At the local level, there appears to be stronger managerial accountability and scrutiny, led by elected members (influenced by their politics, ideology and granular knowledge). This is shining a new light on PH activity, and is bringing an important window of opportunity for change – we found evidence of historical commissioning decisions being challenged, new questions being posed, new suggestions being made, and ‘permissions’ being granted to think differently. This is simultaneously liberating and challenging for PH professionals.
2.13 The role of the DPH in terms of system leadership has changed and become more dispersed. Whilst LAs are now the local leaders for PH, in a more fragmented system, leadership for PH appears to be more dispersed amongst a range of organisations and a range of people within the LA. The new system gives rise to the potentially huge role a leader/chief executive can play in terms of determining the importance and focus of PH goals and activities. The power and potential influence of the DPH depends on his/her relationship with key elected members, and is channelled through a host of decisions regarding structural and managerial arrangements. Issues related to internal organisation and structure – including the position of the PH team within the organisational structure, the line-management of the DPH, and the inter-departmental fora on which the DPH has a voice – seem to be important in determining power, influence and relationships. Rather than being a given, the DsPH leadership role might emerge, given the right ingredients and nurturing.

2.14 With regard to control over PH spending, DsPH felt they largely had control, but in reality this was often subject to council policy and procedures over authorising expenditure, or subject to cabinet ratification. Nevertheless, the majority (96% of DPH respondents in our 2015 survey, 94% in 2014) of councils reported changes such as new, re-designed, or de-commissioned services under the ring-fenced PH budget. However, in 2015 more DPHs reported having changed provider (up from 68% to 90%), re-designed existing services (up from 87% to 94%), de-commissioned services (up from 58 to 69%) and started re-tendering process for others (up from 94% to 100% said yes). In addition there had been an increase in those DsPH who reported setting up new services (69% in 2014 to 73%).

2.15 Many respondents reported having made changes in commissioning for health improvement, and these were taking place particularly in authorities where DsPH felt they had influence, that Health and Wellbeing Boards (HWBs) were having an impact and where there was a culture of collaboration between LA departments.

2.16 The HWB is crucial in ensuring local governance and stewardship. It was envisaged that HWBs could play a crucial role in bringing together a fragmented system and dispersed leadership but were still considered to be in early development. Whilst the HWB was seen as having a role in ‘holding public health activity to account’, it did not have any inherent power to fulfil this role, and it was unclear how this might work. Our findings suggest that HWBs have dual roles of providing strategic leadership and building better relationships whilst at the same time applying pressure and scrutiny. These roles may be uneasy bedfellows. HWB agendas are also often dominated by the Better Care Fund agenda and wider system issues.
2.17 Insufficient attention was paid in designing the new PH system to the important PH functions of district councils when designing the new system. District Councils undertake a variety of PH related activities beyond those resulting from the 1984 Public Health Act including for example, leisure, housing, licensing, and planning (District Councils Network 2014). Working out this relationship (between district councils and county-based public health teams) is crucial and appears to be developing differently in different areas. In some areas district councils are seizing the initiative and taking a key and active part in public health leadership. Elected members here, like their counterparts in the upper-tier authority, are challenging PH professionals, and seeking to influence them, as well as wanting to draw on their professional skills. PH professionals, in their turn, are recognising the potential advantages to be had in engaging with this tier – despite the investment costs. In our two county case study sites, we saw how district-level HWBs were developed, and in some cases with a greater focus for PH discussion and action than the upper-tier boards.

2.18 In the new system, PH staff have had to develop a corporate identity as part of a particular local council. With this identity comes a new form of corporate accountability and political awareness, which some PH professionals have found doesn’t sit comfortably with their professional autonomy and ‘independent voice’. At the same time PH professionals are supposed to not only challenge the council and hold it to account for its progress (or otherwise) on health improvement and health inequalities, but they are also expected to work closely with a range of other organisations across the system. It is clear that this is a challenging agenda for PH staff.

2.19 The shift of PH teams to LAs was accompanied by changes in their relationships with the NHS, and although DsPH continue to provide a well-used service to CCGs, they often feel under-staffed to meet the needs of CCGs. The multiplicity of LA/CCG relationships remains a problem – especially in County areas – which previously would have been addressed at a regional level.

2.20 DsPH also felt poorly supported by national and regional organisations such as the Department of Health, NHS England and Public Health England - a perception echoed by elected members who felt they had received little help apart from that provided by the Local Government Association.

3. Other relevant research

3.1 Members of the research team have also been involved in other relevant projects. The research team collaborated with the NIHR School for Public Health Research project ‘Shifting the gravity of spending? Exploring methods for supporting public health
commissioners in priority setting to improve population health and address health inequalities’ led by Professor David Hunter (University of Durham). Initial findings of the project have been published in the *Journal of Public Health* in September 2015. The findings suggest that the relocation of PH into LAs exposes questions over prioritising PH investment, including the balance across lifestyle interventions and broader action on social determinants of health and the extent to which the PH evidence base influences local democratic decision-making.

3.2 PRUComm’s early research on the development of CCGs included examining the development of HWBs and links to PH. The analysis of these data was published in *Local Government Studies* in 2014. We found that developing HWBs vary greatly in their structure and approach, and that they have a heavy dependence on voluntary agreements to align the strategic plans of the many different new statutory bodies; a significant role for mundane organisational processes in determining the extent of effective co-operation; and problems arising from factors such as size and the arrangements of local boundaries.

4. **Conclusions**

4.1 Our research suggests that the transition has generally gone well, that PH had been welcomed and that their skills and services had been valued and used within the local government. Successful integration appears to have been helped by a number of factors, such as high quality leadership, strong organisational arrangements and clear lines of reporting, shared goals and PH actually delivering good quality work. Elected members felt there was mutual respect between themselves and DsPH, and they welcomed the funding that came with PH.

4.2 Both our case study research and the surveys research suggest that the organisational environment within which PH teams operate is very important in determining ‘success’. This appears to remain in a state of flux with continued organisational turbulence arising from on-going financial constraint within LAs.

- We are currently analysing data from a second round of DsPH and Councillor surveys and case study interviews with a focus on obesity services to provide examples of how the new arrangements impact on relationships and commissioning. Early analysis suggests that changes to commissioning of services has been significant, that organisational restructuring continues and that there are concerns about budget cuts following the removal of ring fencing with an expectation that many authorities will cut budgets beyond those identified by central government. In relation to obesity there have been some positive examples of new approaches being developed but also areas of concern such as the absence of tier 3 services.

4.3 Where available this data has been incorporated but fuller detailed analysis and
reports on the surveys will not be available until January 2016.

4.4 We would welcome the opportunity to give oral evidence to the Committee at which point we could provide further details of our research findings including the latest survey results and analysis of interview data as well as expand on the key points presented here.

14 December 2015

---

¹ Data from 2015 survey but similar to 2014 survey.