Views of public health leaders in English local authorities – changing perspectives following the transfer of responsibilities from the national health service to local government

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Background

The Health and Social Care Act (2012) made large-scale structural reforms to health and care systems in England (Secretary of State for Health 2012, Department of Health 2012a, 2012b, Local Government Information Unit 2012). It also had profound implications for the ways in which the public health function is delivered. In April 2013, local government councils became responsible for key public health staff and functions that had previously sat with the National Health Service (NHS), and a national public health agency (Public Health England, PHE) was established to provide national leadership and co-ordination (DH 2011).

Prior to 2013, local Primary Care Trusts (PCTs) were responsible for planning and purchasing most health services, including for public health. Within these trusts, public health specialists had a leading role in developing strategies, and purchasing or providing services for meeting local health needs. They provided specialist and clinical public health advice to the trusts, and they sat on the executive board and senior management team, where decisions about services and expenditure were made within a relatively simple legislative and governance framework (Marks et al 2010, Marks et al 2011). Whilst many authors (e.g. Hunter et al 2010) have noted that there was often a problematic relationship between the health sector and local government, there was in many cases close working between PCTs and councils, including joint director of public health posts in some areas (Hunter 2008).

Local councils provide a wide range of services, including social care, children's services, housing, leisure, parks, planning, and so on. The structure of local government in England is complex: there are 125 unitary councils that provide the full range of services, and there are 27 areas where the services are split between upper-tier county councils (taking responsibility for social care, education, transportation and strategic planning), and smaller district councils (covering e.g. housing, leisure, environmental health and planning). All of these councils are run by elected councillors, usually affiliated to a political party, who represent and engage their local population, make key decisions, contribute to policy/strategy review and development, and conduct overview and scrutiny roles. Whilst local government is governed by a complex web of legislation and statutory powers and responsibilities (Gains 2004), councils have the same broad powers as an individual to do anything unless it is prohibited by statute. Local government has been described as a 'networked polity', adopting partnership and new forms of accountability at a local level

(Rhodes 1997, Durose 2009, Skelcher 2000, Sullivan 2007). All councils work with a wide range of local partners, and have much freedom to innovate.

Prior to the reform the Government argued that the public health system was too fragmented and structurally inefficient, leading to poor health outcomes [DH 2010, DH 2012]. Crucially, it argued that there was an insufficient focus on the root causes of ill health, and pointed to a lack of accountability with regards to outcomes. Therefore, in its latest reforms, the Department of Health in England wanted to increase the emphasis on health improvement, and to create a more joined-up system that would have a greater impact on the wider determinants of health at local level. Given this, the shift of public health functions into local government made inherent sense. It stood to create opportunities for public health staff to work across a wider front, for example with those locally responsible for leisure, planning and environmental health (Stopforth 2014, Royal Society for Public Health 2015, Association of Directors of Public Health 2015). It was also a move that chimed with national and international research and policy that continued to emphasise environmental and economic determinants of health (Baum 2008, Marmot 2010, Campbell 2012). However, the shift also raises a number of complex organisational and governance issues.

The optimal location of the public health function is a perennial and unanswered question within the evolution of public health policy and practice in England (Hunter et al 2010). The changes and developments over the years have invariably reflected the shifting policy emphases on individual versus collective approaches to public health. There are tensions around how public health should be defined - for instance, whether it is a medical speciality, a multi-disciplinary speciality, or 'everybody's business' (Griffiths et al 2005) - as well as between a public health function that focuses on prevention and one that is involved in planning and managing health provision for existing health problems (Berridge 2000). Hunter et al (2010) noted the varied and ongoing power struggles and turf wars that have been a feature of the public health function since the 1970s. This is not a situation unique to England. An Institute of Medicine report (2002) noted that there is so little evidence concerning the optimal structure and operation of public health delivery systems that policy makers and local decision-makers have little they can use when structurally (re-) organising their public health systems.

A wide range of concerns were expressed prior to and during the reforms to the public health system in England. These included issues raised by expert witnesses to the Local Government and Communities Committee of the House of Commons in 2012 about structural capacity, autonomy of public health specialists, and resources (Riches et al 2015) and those raised in a survey by the Faculty of Public Health of its membership in 2014 about professional status, infrastructure and resourcing (Lambert and Snowden 2016). These and other concerns, alongside the anticipated opportunities afforded by the reforms, were the basis for a three-year research project that examined the impact of structural reforms on the functioning of the public health system in England. This paper presents findings from that study. It focuses on the Government's ambition to create a more joined up, accountable and effective public health system by moving the public health function from the NHS to local government. Therefore, it describes the organisational, functional and managerial arrangements the public health teams adopted, and discusses the extent to which public health leaders felt they had become embedded within their council. It also explores the extent to which public health leaders felt enabled, through the new arrangements, to deliver improvements in local health.

Methods

The study commenced in April 2013 and involved an initial scoping review (Gadsby et al 2014) which provided a framework and thematic focus, detailed case study research in five areas (from March 2014 to September 2015), and two national surveys (2014 and 2015) of public health directors and elected councillors with responsibility for leading on health in the 152 upper-tier and unitary local councils in England.

The case study design provided a methodological framework that supported the analysis of a range of data to investigate the complexity of public health system elements across multiple contexts. By focusing on five case studies, the research could explore in-depth the answer to a range of complex 'how' and 'why' type questions, taking into consideration the interplay with local contextual conditions. This approach was ideal for examining the processes of the transfer and embedding of the public health function as they unfolded, in a structured way, and in relation to the core themes identified in the scoping review. It also afforded an examination of multiple perspectives and inter- and intra-organisational relationships.

Each of our five cases was what might be defined as a local public health system, which centred on the main upper-tier or unitary council, and encompassed the NHS bodies and other councils (lower-tier or neighbouring) with which it had close connections and/or sharing arrangements. The cases (described in table 1) were selected to be representative of a range of characteristics (including council type, size, urban or rural location, varied socio-demographic and economic circumstances and different political control) but were not selected as being representative of local authorities generally. The selection criteria were designed to ensure that the sample included a broad range of different types of authority. Given the range of different criteria for site selection it was not envisaged that the findings of sites would be compared but rather that different sites would provide rich pictures of how public health was developing across local government in England. Across the five cases, we undertook 103 semi-structured interviews (see table 1), with: 36 council public health staff; 18 elected members; 25 council non-public health staff; 13 provider organisation staff; 6 CCG staff and 3 other respondents at regional levels. Fifteen meetings were observed and documentary evidence was collated to enrich our understanding of the case studies. A further five interviews were conducted with key informants outside of the case studies, particularly to explore national and regional level issues and relationships with/within PHE.

Table 1: Case study sites here

The surveys of 152 councils were carried out in July 2014 and September 2015 - 15 and 29 months after they were officially given responsibilities for public health. The survey methods and detailed analysis of the first round of surveys have been described more fully elsewhere (Jenkins et al 2015a). They were focused on the organisation and management of public health teams both within and between councils, lines of communication, budgetary responsibility and managerial accountability, and how well the public health team was functioning and having influence across the council. They also asked about wider relationships for example with Public Health England (PHE), Health & Wellbeing Boards (HWBs) and Clinical Commissioning Groups (CCGs).

Directors of public health (DsPH) and elected members with lead responsibility for health (EMsPH) were asked to respond to slightly different on-line surveys at two time-points so that two different perspectives could be explored over a period of time. In the first round, we had replies from DsPH in 96 councils (63%), and from EMsPH in 54 councils (36%). This level of response was nearly as high as that obtained by the Association of Directors of Public Health and considerably higher than other contemporaneous research (ADPH 2015, ADPH 2016, Davies et al 2016). The second round achieved a similar level of response from elected members (48 replies, 32% of councils) but a lower response from DsPH (74 replies, 49% of councils). The latter calculation does not take into account the fact that some councils shared a DPH or had no one in post.

The surveys were completed satisfactorily both in terms of replying to all the questions and writing in additional comments to elaborate on a ticked box response. In all the surveys, there was a good representation of English regions, types of authority, political party in power, population size and public health budget per head of population. This was particularly true for the 59 authorities where there were replies to the DPH survey in both years, enabling us to track change over time. It was concluded that the survey responses were sufficiently numerous and representative of all England authorities to provide robust and reliable information.

Findings
The organisation of public health teams
Local councils were given the freedom to organise their incoming public health teams in any number of ways. This raised concerns from some commentators about the capacity and autonomy of DsPH within local bureaucracies that might make them subordinate to other officials (House of Commons Health Committee 2014). Our research, like others (DH 2012a, 2012b), found considerable variation across the country with regards to the 'location' of the public health team and its director within the structure and hierarchy of the council. Within councils, DsPH sit alongside, or sometimes under, other directors who are often presiding over directorates that are far more significant in terms of staffing and budget. Also, elected members in councils have an important political and corporate leadership role across the

system. The strength and position of the public health team, and their skills in working with elected members are, therefore, very important.

As shown in figure 1, approximately half of DPH survey respondents in 2015 reported that their team was a section of another directorate. The next most common arrangement was for the team to be a distinct public health directorate within the council - 26% in 2015 (n=19) compared to 28% in 2014 (n=25). Some teams - 7% n=5 in 2015 (compared to 6% n=5 in 2014) were distributed across directorates or functions, or across multiple councils. The number of councils adopting a merged model in which public health and another council directorate were combined had increased from 6% (n=5) in 2014 to 11% (n=8) in 2015. Our case study findings suggested that the organisation of public health teams was far from settled, with many ongoing changes and restructures. There were no clear types or models of arrangements that emerged from the data.

Figure 1 here

Behind this apparent picture of stability regarding where public health teams were located within their authority, our surveys revealed a much higher level of change for individual authorities. Nearly half reporting that they were in a new arrangement by the time of the second survey. This included public health teams who had been in a distinct directorate in 2014 but were no longer in 2015 (this was the case for 7 out of 15, or 47%), and teams who were initially a section of another directorate in 2014 but were in a different arrangement by 2015 (11 out of 33, 33%).

Accountability

These different arrangements appeared to have implications for managerial accountability. In 2015, 47% (n=34) of DsPH reported being managed by the chief executive – a slight increase from 42% (n=38) in 2014, but this was most likely to be the case where public health was a distinct directorate (79% n=15 in 2015 and 88% n=22 in 2014) and least likely where public health was a section of another directorate (21% n=8 in 2015, 17% n=8 in 2014). Others tended to be accountable to whoever was leading the directorate in which public health was located. Just over half the professional public health leads (53% n=39 in 2015) were on their

councils' most senior management team. Where public health staff were distributed across the organisation it was described by one council based Public Health consultant as a threat to maintaining '… *professional culture and skills'* with other interviewees noting a possible clash between professional values and organisational values. For example, a local government policy officer in one case study noted that there was '… *a genuine tension for some of the people who've come over from public health; is their ultimate responsibility to their profession or is it to their organisation?'*

An important change for public health staff within their new setting was their relationship with elected members who, in councils, are the key decision makers. Decision-making processes usually involve close working with the lead elected member, a number of committees, sub-committees, and cross-departmental groups, and various consultations both with councillors and the public. Public health staff interviewed as part of our case study research reported that whilst these processes were lengthy, onerous, and difficult to adjust to, they had clear value in terms of the scrutiny they bring. A programme manager for childhood obesity in one of our sites commented that:

> *'it's actually a very robust process and explains well how we are going to spend public funds, because you are justifying your business needs and getting feedback to see if it's the right thing to invest in, you've got chances for peer review, and you can get an understanding from your colleagues about where they think would be a better area to focus on. You have to get legal clearance, financial clearance, so it's all formally done, and then it goes to the decision makers. So by the time it gets to the cabinet it has been through all of that'.*

Relationships between public health officers and elected members are an important aspect of building a more accountable, joined-up and effective system. Our findings overall suggested that relationships were good and valued by both parties. In most of our case studies, the elected members were positive about and interested in public health, and had often played an important role in cross-directorate working and in helping the public health team to become embedded within the council. In one of our sites the cabinet member with the health portfolio explained, in June 2014, that she

"was very keen and asked them [public health] to put together the programme for how we engaged all the other departments within the council and... which they've done, and that will be a programme that starts very soon".

In general, public health staff felt their work was valued by the council and elected members, and councillors also talked about their public health teams in a positive way. In the 2015 survey, 52% of DsPH (n=38) and 61% of EMsPH (n=23) felt that the teams were 'definitely' valued across the council, citing a variety of enablers for this such as strong leadership and quality of their work. This view is reflected in the following quote from a county councillor:

'I'm impressed with public health … they're working very hard with limited funds, and so with public health more than anybody they've got into the joined up thinking. So public health … are doing really well as far as I'm concerned and they are setting an example so some other areas could follow the same'.

Capacity and responsibilities of public health teams

We found a wide variety of inter-council sharing arrangements which were mainly between unitary councils. In 2014, 32% of DsPH (n=29) led public health teams providing services for between two and eleven authorities. While the same proportion reported sharing arrangements in 2015, this was a new arrangement for five authorities (two of which were temporary). Interestingly, of the 73 DsPH responding in 2015, 14% (n=10) thought that there would be new arrangements between councils to share public health staff or responsibilities. Public health staff were increasingly being 'stretched' across a greater geographical area and/or range of organisations providing challenges in learning new ways of working. They were also increasingly being 'stretched' across other service areas. In the 2015 survey, 51% of DsPH (n=37) reported having gained responsibilities from other parts of the council (an increase from 36% the previous year, n=32). Responsibilities were changing in a complex way however: in 2015, 11% reported relinquishing responsibilities (down from 25% in the previous year), and 39% reported sharing responsibilities (previously 41%).

There were changes in the size and composition of public health teams following the transfer to councils, including significant reductions in the numbers of director posts, consultants and specialists being reported in the 2014 survey. By 2015, our survey results suggested that

reductions in director posts had become much rarer, but the number of public health consultants and specialists continued to fall in 28% of councils (n=20). This was also observed in our case studies, where we saw management-type posts increase, and specialist posts decrease. Sometimes this was due to 'pull' factors, where public health professionals opted to work at PHE or in local or national NHS bodies, sometimes for better terms and conditions.

And sometimes this was due to 'push' factors: interviewees in our case studies talked about having to address skill gaps in their team following the transition, for example to be able to carry out a previously taken-for-granted function (such as finance or procurement), or to be able to address the new requirements for scrutiny and accountability within the council (such as business and strategy planning). By the end of our field work, funding cuts were also having an impact on staffing resources in our case studies, leading to staff reductions and changes in structures. In the 2015 survey, DsPH were asked about their expectations for continuing organisational change affecting their teams, and both DsPH and EMsPH were asked how impending funding cuts would affect public health staffing levels. Many DsPH were expecting further re-structuring (46%, n=33) and changes in the size or composition of the public health team (45%, n=33), although fewer (14%, n=10) thought this would lead to the development of further arrangements between authorities to share public health staff or responsibilities.

Embedding public health within the councils

Our findings suggest that it took a considerable amount of time for public health teams to adjust to their new organisations. Whilst the initial period of culture shock observed in the first year had largely passed by 2015, there was a protracted process of adapting to new systems and ways of working. Though they were still far from settled, public health professionals and elected members were largely positive about the way staff had become embedded and integrated, how the public health staff were viewed and how public health services were being utilised. DsPH in our case studies were positive about the way that the teams had quickly forged and maintained good relationships within the council. We also found good examples of public health staff making important contributions to changing the way local councils were working, and evidence that a public health perspective was being embedded in the work of the council, as these quotes illustrate:

'We're breaking down some of those barriers by starting to facilitate working between the directorates now on things that actually you think oh did it take public health to get everybody together?' (DPH)

'even when we're not involved in stuff I hear now other colleagues saying, well, we're taking a public health approach to this, so we're doing the analysis of all the data first and try to understand where we are before we decide where we're going to get to.' (DPH)

'So quite often, you know, no matter where our leader goes, he hears all the other directorates talking about public health and we're doing this with public health or we're doing that with public health.' (PH consultant)

Survey responses from both DsPH and EMsPH supported the view that public health staff were valued and their advice was trusted. The level of demand for public health advice had remained fairly static from 2014 to 2015; 44% (n=32) of the DsPH in 2015 reported that other departments were 'definitely' asking for public health advice (as opposed to 'to some extent', 'not really', 'too early to say', or 'don't know'). This advice and support tended to be in: provision of data; needs assessments; monitoring against goals or targets; inequalities analysis; and commissioning.

Our survey findings also showed that other council departments were increasingly being required to collaborate with public health on their plans (15% n=13 in 2014, 34% n=23 in 2015). However, a third (33%, n=22) of councils responding to the 2015 survey reported that there was no requirement to collaborate, with the remainder only required to collaborate under certain circumstances. In our case studies we found a range of approaches to cross-council collaboration. In one case study site, they were progressing a 'whole council approach' to public health, which aimed to utilise council skills and levers, and embed public health priorities within the council. Initiatives included a tool to help the council think in a more public health way, a fund to enable people from across the council to submit ideas for new projects with a public health focus, and a transformation board to help public health embed across the council. In another case stud site, the strategic aim of the public health team was *'to have health in all policies'*. In a third, we saw how the approach to health improvement

was shifting as the public health team became integrated within the council. The public health team were starting to move away from an approach that was solely about individual behaviour change programmes. The DPH described how the new approach was:

> *'using existing council resources in a very different way, so it'll be tapping much more into community assets resources, bringing to the added value of all the things the council can bring to the table, whether it's volunteer support programme, the use of libraries, community facilities, neighbourhood development work, countryside volunteers, where we use green space … We've also created greater links with the transport planning process and feeding in much more strongly on the public health agenda there, looking at some of the issues around community safety, standardising speed limits in certain parts of [the borough]' .*

These approaches fit with the concept of *Health in All Policies*, an approach promoted by WHO and in the UK by Public Health England and the Local Government Association (de Leeuw and Peters 2014, LGA 2016a).

The responses from our surveys showed that both DsPH and EMsPH felt confident in their ability to influence the council's priorities for health (see figure 2 showing how many said this was 'always' the case) and that, following the reforms, they were more able than before to deliver real improvements in the health of the local population (91% n=31 of elected members in 2015, and for DsPH rising from 54% n=46 in 2014 to 63% n=42 in 2015). Both groups felt they had greater influence on the council as a whole and beyond, such as in workplaces and schools. While elected members were also positive about having greater influence over the work of CCGs, DsPH felt that their ability to influence CCGs was diminishing (37%, n=31 said they had less influence in 2014, and 48%, n=33 in 2015)

Figure 2 here.

Some of the ability to influence others came from the position of the DPH as a statutory member of local Health and Wellbeing Boards (HWBs). These boards bring together council, health and other agencies to provide an overarching strategic framework within which all agencies should work (Coleman et al 2014). Most DsPH responding to our surveys were aware of the benefit of being on the HWB, and felt it enabled them to influence decision-making

more widely across their authority and beyond (see figure 3). However, when asked how well their HWB was performing, respondents expressed concerns. There was a drop in 2015, compared with the previous year, in the proportion who said the HWB was definitely being instrumental in identifying the main health and wellbeing priorities (down from 60%, n=49, to 48%, n=31 for DsPH and down from 86%, n=37 to 71%, n=24 for EMsPH).

Figure 3 here

In our case studies, we found little evidence that HWBs were addressing strategic public health issues, as they tended to focus on issues such as integration and other national policy priorities. A councillor and chair of the HWB in one of our case studies said:

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

One indicator of cross-council 'embeddedness' of public health is to look at the way in which the public health budget is used within councils. At the time of transfer, a public health grant was given to councils that was ring-fenced for three years (extended in 2015 to March 2018), but which was subject to budget cuts of 3.9% per annum until 2020. In the surveys, DsPH were asked who authorised expenditure from the public health grant. In 2015, 66% (n=46) of respondents said the DsPH had sole authority (up from 58% n=49 in 2014); for the rest it was a shared responsibility.

In two case studies public health investments into other parts of the council (such as children's centres or environmental health) helped to build relationships, and embed public health outcomes and ways of working in other departments. A transport manager in one site noted how public health had co-funded various initiatives with them, and discussions were underway on pooled budgets in certain areas. In another site, a public health lead commented that:

'We've gone through a process here by which over two and a half million pounds of the public health budget is now going into broad council services that are delivering on public health outcomes, and that's been done very appreciatively here as a process'.

This situation was reflected nationally. In the 2014 survey, 88% (n=76) of DsPH and 65% (n=30) of EMsPH said that the public health budget was being used to invest in other council departments; the 2015 survey showed that this continued to be the perception. In both years, a lot more DsPH than EMsPH felt that the budget was being used in this way (Figure 4). However, in some cases public health received additional investment. This was the case in both years, and in 2015, slightly more DsPH said they had received additional funds for the public health team's work (26% n=18 in 2015, compared to 19% n=16 in 2014), although the amount of extra finance is not known.

Figure 4 here

A minority of DsPH (11% n=9 in 2014 and 13% n=9 in 2015) considered that they had 'quite a lot' of influence over other departments' expenditure within their council. When we tested for statistical association between the replies to these last two questions we found no association between the requirement for other departments to collaborate with the public health team and the director's perception of having a lot of influence over their expenditure. Within individual councils, replies varied over time to the question about the DPH's perceived influence over other departments' expenditure, with nearly a half (48%, n=25) giving a different answer in 2015 compared to 2014, despite the fact that the overall figures suggested there had been little change.

Discussion

The large-scale re-structuring of public health functions and staff following the Health and Social Care Act 2012 led to uncertainty about (and research into) how the move from the NHS to local government would work (e.g. Willmott et al 2015, 2016). For those working to improve health, there were clear potential benefits in being alongside local council departments with responsibility for health-related fields such as transport, leisure, local planning, licensing, education and social care. However, the reforms also brought huge

physical, organisational and cultural transitions for public health teams, which threatened to distance them from former NHS colleagues and required new relationships to be built within their local council (Riches et al 2015).

Whilst a considerable amount of organisational and structural upheaval was anticipated during the transition period, it was also expected that opportunities would be afforded for re-organisation of public health teams and to embed public health both organisationally and functionally within their new local council setting. Some councils made changes in advance of the formal transition date, which helped public health leaders to build up experience in their new surroundings, and allowed a more gradual pace of change. Others set up sharing arrangements across several councils in order to make more efficient use of staff, and maximise access to public health expertise.

Our research found that in many councils, the initial changes were followed by more re-organisation and re-structuring as a result of continuing resource and organisational pressures on local councils. Public health leaders were fully expecting this process to continue. The period of relative calm that might have been expected following transition never occurred. Detrimental effects of continuing change could be seen in the lack of continuity of experienced public health leadership and the loss of staff with specialist public health knowledge. Overall, these findings on organisational and structural change across the system as a whole is confirmed in other research (Association of Directors of Public Health 2015, Stopforth 2014). However, they also illuminate for the first time the much higher levels of change being experienced within individual councils that get masked by the headline figures.

Phillips and Green (2015) argued that the context of decision-making in local government is set within a distinctly different organisational cultural context to the NHS:

> *"…local authority officers emphasise their accountability to a number of stakeholders: their local population, new public management and elected councillors. They must arbitrate between the needs of different publics and integrate their needs with the financial and legislative constraints from higher tiers of government. At different times the same course of action may be more or less palatable depending on the particular constellation of local and national policies, public opinion and funding." (p501).*

It was not surprising, therefore, that public health teams struggled to acclimatise to new organisational structures, cultures and practices. Even where public health teams previously had joint appointments with local councils, there was still something of a 'culture shock' for individuals working in their new environment (Peckham et al 2015). It has taken a long time for public health staff to become familiar and at ease with the different ways of working required within councils. However, our findings suggest that public health teams successfully prioritised the building of good relationships in the early phase of transition, and consequently were becoming embedded in their new environment. This was an impressive result, given the continuing level of organisational churn and the effort required to work across local council departments. Over time, public health teams continued to make progress in their level of integration as the skills they offered were increasingly valued and trusted. Our findings indicate that there were high levels of enthusiasm and commitment to making the reforms work, and increasing positivity about the impact of public health within local government – despite the challenging environment. This positivity has also been reflected in a series of case studies reported in other recent studies (LGA 2016b, Royal Society for Public Health 2015).

The increased positivity is perhaps more surprising when considering the mixed views and experiences related to the organisational position of the DPH, their varied experiences influencing local council decision-making, and the variety of reporting and accountability structures. It seemed on one hand as though public health leaders had lost some power and autonomy. However, there had at the same time been gains in terms of responsibilities, additional funds, and increased collaboration with other council departments. These findings resonate with the findings of other studies (Association of Directors of Public Health 2015, LGA 2016b, Willmott et al 2016). However, we also found variability over time in how much public health leaders felt they could influence expenditure of other departments, and some differences of opinion between DsPH and EMsPH on who controlled the public health budget. In the spirit of change, with regards to public health becoming a whole council responsibility, over time, more DsPH recognised that they had a shared responsibility for spending the public health budget.

Although constant organisational change had led to poor continuity of individual public health leaders on the most senior corporate team, DsPH felt that over time they were gaining in their

ability to influence their council's priorities for health. Public health leaders felt that the reforms had allowed for a more direct and integrated approach to improving health locally, as they enabled public health teams to work alongside those with responsibility for the wider determinants of health. It has been suggested elsewhere that this new alliance has the potential to ease pressure on the NHS if it can deliver better place-based health and disease prevention interventions (New Local Government Network 2016). However, continuing budgetary constraint has been increasingly highlighted as a risk to local health and social care economies (Buck, 2015, CQC 2016, Cooper 2015, Iacobucci 2014, Iacobucci et al 2015, Williams, 2015). There have also been more general concerns voiced about the lack of development of the public health workforce and their capacity to deliver the new agenda (Faculty of Public Health 2016).

By autumn 2015, it was clear that more re-organisation and change were inevitable. Further re-structuring and down-sizing plans were in place or foreseen in many councils. Public health leaders were expecting widespread cuts in response to reductions in local council budgets, and when the ring-fencing was removed from the public health budget. The necessary cuts would not only fall on staff but also on both mandatory and non-mandatory services. These findings entirely agree with other research describing the sequence of cuts that start with staff and move on to services (Hastings 2015) and feed into the debate on whether local councils faced with austerity merely cope or display the kind of resilience that enables them to make fundamental change (Shaw 2012).

The findings of this study clearly demonstrate that while the move of public health responsibilities was seen as a natural shift (Baum 2008, Marmot 2010, Campbell 2012) the experience has, for many public health teams and local councils, been an enormous challenge. Adapting to new organisational and governance arrangements has impacted on both the structure and role of public health teams in a number of profound ways. Some of the specific concerns identified before the reforms were clearly unfounded, but our research shows that there have been unexpected consequences, such as pressures to change team structures in order to better reflect local council business models. There have been a number of key positive impacts, with many public health teams welcoming councillor involvement and engagement with other local council departments, even if this has increased the complexity of decision-making compared to when they were in the NHS. Therefore, whilst some of the

opportunities identified have been realised, many remain highly dependent on a range of locally contextual factors, and most are simultaneously threatened by continuing resource constraints and organisational turbulence. What role public health will be able to play in the development of the new Strategic Transformation Plans (STPs) and their implementation will depend crucially on the extent to which wider partnerships – such as through HWBs – can influence local strategic objectives. In the process of development there has clearly been a shift from STPs as an opportunity to address prevention and public health needs, to more of a focus *"…on how STPs can bring the NHS into financial balance (quickly)."* (Alderwick et al 2016:4).

Overall our research suggests that the development of the new public health system in England is still in progress with the internal organisation of public health in local councils very much in a continuing state of flux. The additional organisational upheaval that has been a feature of local government has had a significant impact on the way the organisation of the new public health function is developing. A key message emerging from our research is that the reform and associated policies paid insufficient attention to the nature and quality of relationships across the various organisations and individuals that constitute the new public health system in England. Consequently, whilst some of the challenges identified during the passage of the Health and Social Care Bill have been averted, the future development of a locally organised public health system still remains uncertain.

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Table 1: Case study sites

Site	Description	Number of interviews
A	Large county council (Conservative), including sample of 2 different sized district councils and adjacent unitary council	23
B	Cluster of three urban unitary councils (two Conservative, 1 Labour) with shared DPH	13
C	Urban metropolitan unitary council (Labour)	23
D	County council (Conservative), including sample of 2 different sized district councils, adjacent county council and unitary city council	22
E	Urban metropolitan unitary council (Labour), working with network of other urban unitary authorities	22

Figure 1: How is your public health team arranged in this local authority? (2015 DPH survey N=73, 2014 DPH survey N=90)
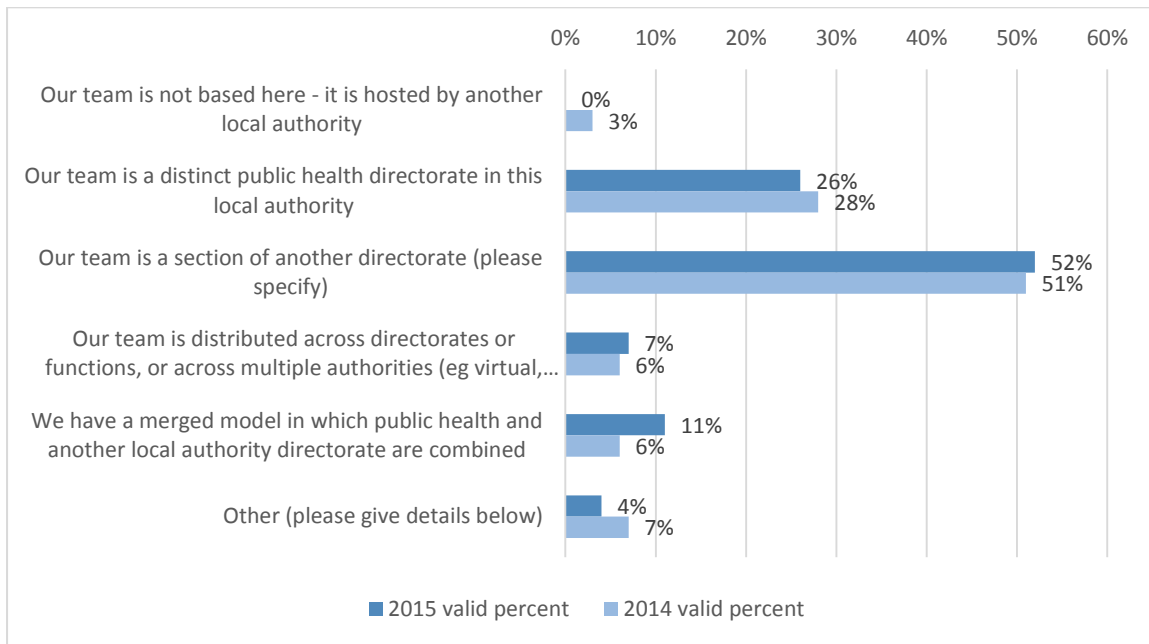

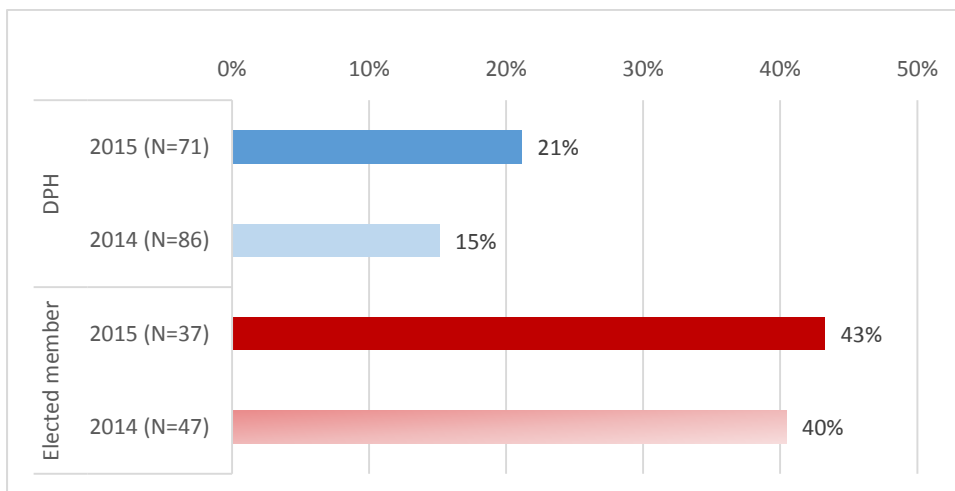**Figure 2. Percentage saying they 'always' feel able to influence the priorities of their local authority**

Figure 3. Views on the benefits of being on the Health & Wellbeing Board (% agreeing)

The chart shows responses comparing DsPH in 2015 (N=66), DsPH in 2014 (N=82), EMsPH in 2015 (N=35), and EMsPH in 2014 (N=46):

Being on the HWB has allowed me to influence decision-making in my own organisation
- DsPH in 2015: 74%
- DsPH in 2014: 66%
- EMsPH in 2015: 69%
- EMsPH in 2014: 83%

Being on the HWB has allowed me to influence decision-making in other organisations locally
- DsPH in 2015: 74%
- DsPH in 2014: 68%
- EMsPH in 2015: 60%
- EMsPH in 2014: 65%

Being on the HWB has allowed me to strategically influence work in the local health/social care economy
- DsPH in 2015: 83%
- DsPH in 2014: 77%
- EMsPH in 2015: 69%
- EMsPH in 2014: 65%

Being on the HWB has allowed me to engage with the development of the Better Care Fund
- DsPH in 2015: 64%
- DsPH in 2014: 67%
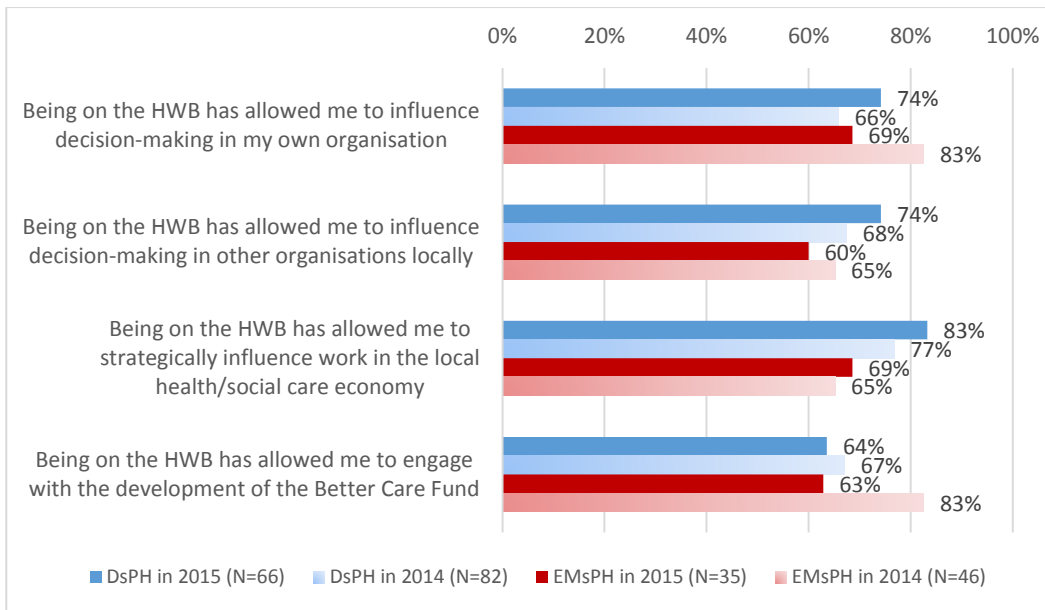- EMsPH in 2015: 63%
- EMsPH in 2014: 83%

Figure 4. Percentage saying that the ring-fenced public health budget has been used to invest in other local authority departments?

- DsPH in 2015 (N=70): 89%
- DsPH in 2014 (N=86): 88%
- EMsPH in 2015 (N=35): 69%
- EMsPH in 2014 (N=46): 65%