

## **THE ROLE OF LOCAL AUTHORITIES IN HEALTH ISSUES: A POLICY DOCUMENT ANALYSIS**

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**Disclaimer:** This research is funded by the Department of Health via the Policy Research Programme. The views expressed are those of the researchers and not necessarily those of the Department of Health.

## CONTENTS

<b>GLOSSARY .....</b>	<b>2</b>
<b>BACKGROUND .....</b>	<b>3</b>
<b>METHODS.....</b>	<b>5</b>
<b>GOVERNANCE.....</b>	<b>7</b>
Localism .....	7
Accountability .....	10
Funding .....	12
Authorities and responsibilities .....	13
i) Authority .....	14
ii) Autonomy .....	15
iii) Exerting influence .....	16
<b>RELATIONSHIPS .....</b>	<b>18</b>
Integration .....	18
i) Role of Health and Wellbeing Boards .....	18
ii) Conflicts of interest.....	20
iii) Boundary-spanning issues .....	21
Collaboration.....	22
i) NHS structures .....	22
ii) Local authority departments .....	24
iii) External agencies .....	25
iv) Government.....	26
Workforce issues.....	26
i) Staff transfer .....	26
ii) Training .....	29
<b>PUBLIC HEALTH ACTIVITY .....</b>	<b>31</b>
Defining public health .....	31
New ways of working.....	32
Social determinants of health.....	33
<b>DISCUSSION AND RECOMMENDATIONS .....</b>	<b>35</b>
Challenges .....	35
Opportunities and enablers .....	38
<b>REFERENCES .....</b>	<b>42</b>
<b>APPENDIX 1: LIST OF ORAL WITNESSES .....</b>	<b>44</b>
<b>APPENDIX 2: LIST OF WRITTEN SUBMISSIONS .....</b>	<b>46</b>
<b>APPENDIX 3: CODING FRAMEWORK .....</b>	<b>47</b>

## GLOSSARY

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**BMA:** British Medical Association

**CCG:** Clinical Commissioning Groups

**DCN:** District Councils Network

**DPH:** Director of Public Health

**DsPH:** Directors of Public Health

**GP:** General Practitioner

**HSCA12:** Health and Social Care Act 2012

**HWB(s):** Health and Wellbeing Board(s)

**JSNA:** Joint Strategic Needs Assessment

**JHWS:** Joint Health and Wellbeing Strategy

**LSHTM:** London School of Hygiene and Tropical Medicine

**NHSE:** NHS England

**PCT:** Primary Care Trust

**PHE:** Public Health England

**PHOF:** Public Health Outcomes Framework

**PRUComm:** Policy Research Unit in Commissioning and the Health Care System

**RCN:** Royal College of Nursing

**UKFPH:** UK Faculty of Public Health

## BACKGROUND

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The 2012 Health and Social Care Act (HSCA12) initiated a major reform of the health and social care systems in England. The structural reforms have had a profound impact on the way public health is organised, commissioned and delivered. In particular, the key duties and responsibilities for improving health and coordinating local efforts to protect the public's health and wellbeing have been transferred from the National Health Service (NHS) to Local Authorities. In addition, a new executive agency – Public Health England (PHE) – was created to deliver services at a national level, take a lead for public health, and support the development of the workforce (DoH, 2011a).

Among the new responsibilities of local authorities is a statutory duty to establish a Health and Wellbeing Board (HWB). This is a formal sub-committee of the local authority comprising a range of stakeholders, including NHS and local authority representatives. HWBs have a duty to encourage integrated working between the NHS, social care and public health. They are tasked with periodically conducting a Joint Strategic Needs Assessment (JSNA) of their area to identify public health priorities. This should inform a Joint Health and Wellbeing Strategy (JHWS) detailing how public health issues can be addressed.

The Director of Public Health (DPH), now employed by the local authority, has an important role contributing to the work of the HWB. It was also expected that they would be able to work across organisational structures within local authorities to promote public health. DsPH also have a duty to work with new GP-led Clinical Commissioning Groups (CCGs) which have taken over from Primary Care Trusts (PCTs) in commissioning most healthcare services for their population.

The Health and Social Care Bill, containing the proposed legislative changes required to implement the reforms, was introduced to the House of Commons in January 2011. The Bill had a turbulent journey through Parliament, and there were many critiques of it published by unions, royal colleges and organisations representing the health professions. Also prior to the Act being passed, 26 expert witnesses (appendix 1) were invited to give evidence in Parliament regarding the reforms before the Communities and Local Government (CLG) Select Committee. These individuals represented a variety of stakeholders, including public health organisations, the NHS, Local Government and the Department of Health. The Committee also received 40 written submissions to their inquiry (appendix 2). Following submission of the evidence, the Committee produced a 265-page report summarising the evidence and giving recommendations (CLG Select Committee, 2013). This report, which included complete transcripts of both oral and written submissions, provides a rich and informed data on which to base an analysis of the proposed new public health system.

This analysis of the Select Committee report was conducted under the auspices of a project called PHOENIX: 'Public Health and Obesity in England – the new infrastructure examined' (PRUComm 2013). The PHOENIX study, being conducted from April 2013 to December 2015, 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. A key focus is to explore the impacts of structural changes at national, regional and local levels on the planning, organisation, commissioning and delivery of health improvement services. The work was commissioned by the Department of Health and is being conducted by a collaboration of academics from different Universities: Kent, Manchester and the London School of Hygiene and Tropical Medicine (LSHTM), as part of the Policy Research Unit in Commissioning and the Health Care System (PRUComm).

Evidence from the Select Committee report has highlighted central themes pertinent to the transition to, and implementation of, the new public health system. The identification of these themes has additionally led to the creation of a coding frame (appendix 3), to be used in other aspects of the project. The systematic analysis of the report itself provides a reference point for the rest of the study, by identifying key challenges and opportunities at baseline.

## METHODS

The report itself was imported into NVivo (v10). The text was read and emergent codes were identified. Following subsequent reading these codes were unified and aggregated into key themes. The structure of these themes was influenced by the van Olmen 'Health Systems Dynamic Framework' (van Olmen et al., 2012), which was adapted by our project team for greater relevance to a public health system (figure 1). This model emphasises that health systems should be geared towards health outcomes and goals, and that they are, and should be, based on values and principles. Resources are present as input in the system, but the organisation and delivery of 'public health practice' is considered the most central element.

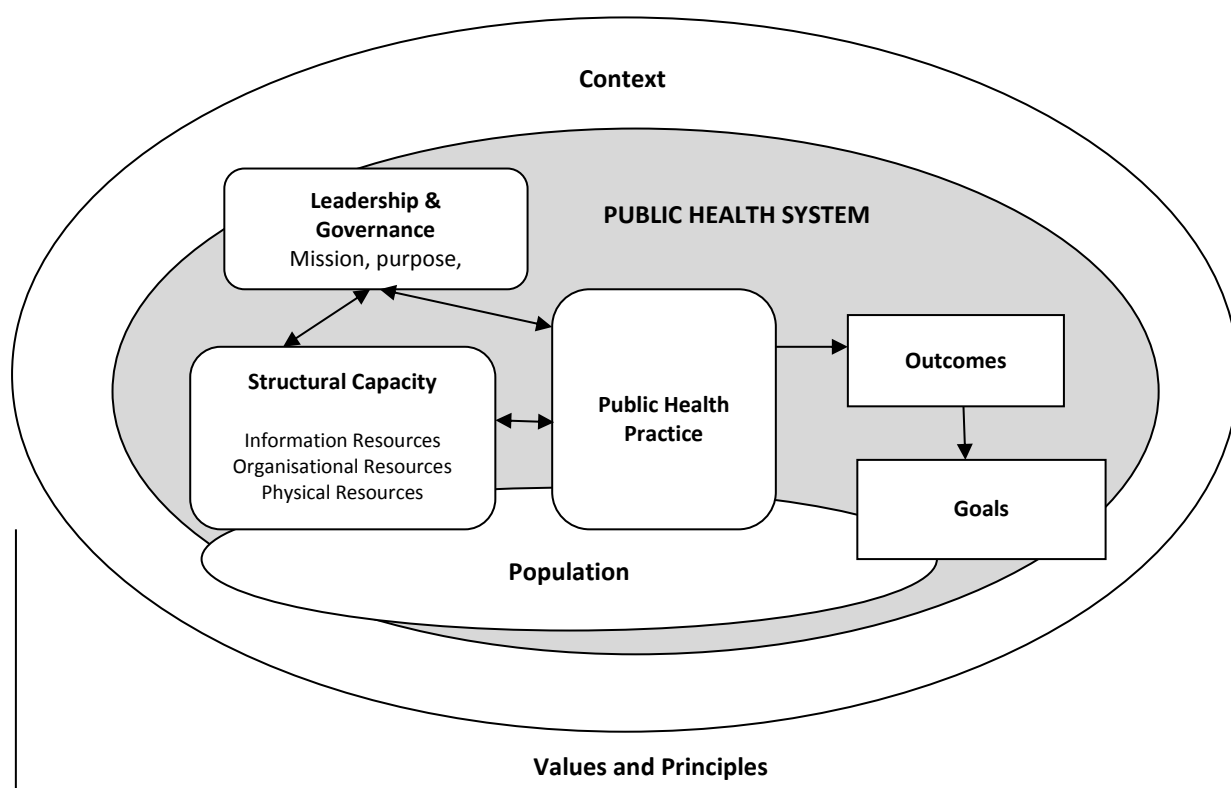


Figure 1: A Public Health systems dynamic framework, adapted from van Olmen et al., 2012

Public health practice is produced at the interface with the population, and this occurs within a particular context. Public health activity, and the structural capacity to conduct it, is determined in large part by leadership and governance. Leadership and governance will entail policy guidance, legislation, coordination between actors and regulation of different functions, levels and actors in the system, an optimal allocation of resources and

accountability towards all stakeholders. This will be very much influenced by context (e.g. austerity), but also by values and ideologies. The framework encourages a systemic approach to the public health system, and is applicable, as a cognitive device, to an analysis of a system at national (macro), meso or micro level. This allows us to organise the observations that come from research (including this documentary analysis), and to facilitate the identification of problems at different levels in the system.

The resulting coding framework can be found in appendix 3. The headings were then further grouped into three overarching themes: Governance, Relationships and Public Health Activity. These were consistent with the themes being used in other parts of the project. A decision was made to use these as the basic structure of analysis, to allow ease of comparison.

Once the text was fully coded, qualitative data analysis was conducted using a Framework Analysis approach (Ritchie and Spencer 1994). This allowed key evidence to be reviewed according to each element of the model. All quotes have identifiable names since the report is available in the public records of the Committee proceedings. This is a preliminary report which summarises key quotes and outcomes for each key theme.

## GOVERNANCE

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Issues relating to governance within the new system were a primary concern of the Select Committee during the evidence sessions. A fundamental driver of the reforms was a perception of the advantages to be gained from placing public health under local democratic control within local authorities. The CLG committee report makes frequent reference to the “*spirit of localism*”, whose purpose it describes as “*not only to bring decision making closer to local people, but to make it accountable to local people*” (CLG Select Committee, 2013, p39). The concept of localism is useful to describe the nature of the changes in governance arrangements. These changes inevitably affect the authority and responsibilities of different public health structures while changing accountability regimes, themes which will also be explored within this section.

### Localism

The concept of localism was fundamental to the reforms themselves. The UK Government Coalition Agreement signed in 2010 included a statement that “*the time has come to disperse power more widely in Britain today*” (HM Government, 2010, p7). This rhetoric was followed by the passage of the Localism Act 2011 which committed the Government to a policy of decentralisation. This was reflected in a briefing paper accompanying the HSCA12:

*‘The Government believes that many of the wider determinants of health (for example, housing, economic development, transport) can be more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations.’*  
(Department of Health, 2012a, p1)

The Select Committee’s summary of the report defined the purpose of localism as:

*‘to bring decision making closer to local people, to make it accountable to local people and to allow local people to develop the relationships that work for them locally’*

However, many contributors to the report focused primarily on the transfer of “decision making” powers to local populations, rather than how these powers could be made accountable to the communities involved (these issues will be further explored in the next section). The term was frequently used as a justification for the increased role of local authorities in public health delivery, typically by spokespersons from the Government, Department of Health or local authorities. The then Government spokesperson, Anna Soubry, emphasised the central importance of localism to the reforms, but does not address issues of local accountability:



*'... at the end of the day, we are all about localism and letting health and wellbeing boards determine their own composition and work, based on their own strategic needs assessment of their area.'*

**Anna Soubry**

(Then) Parliamentary Under Secretary of State

This highlights the perceived advantage in reducing the influence of central government over local public health arrangements. However, it does not make clear what this form of scrutiny is to be replaced by. Undoubtedly this marked a transition from the more hierarchical system of governance which existed previously. This was acknowledged by Tim Baxter representing the Department of Health:

*'I have been in the Department of Health for 21 years, and it is true that historically the relationship we have had with the NHS has been a more top-down prescriptive model.'*

*'The principle of localism is, of course, that local authorities should make the decisions and we are not going to tell them exactly how to do it.'*

**Tim Baxter**

Department of Health

These quotes suggest that one advantage of the 'localism' agenda as defined above, would be less direct control by the Department of Health over public health structures. In the previous system PCTs were responsible for the delivery of public health. As NHS structures, the implication was that PCTs were less independent than local authorities are able to be. It also implies that the previous hierarchy originated from the Department of Health, which may have favoured 'healthcare' related interventions.

By contrast, as explored later in this report, local authorities have a remit which extends beyond healthcare to include wider determinants of health such as housing, leisure, planning and employment. A local authority's ability to address such determinants formed a key part of the Government's localism agenda, as defined above. When discussing the ability of local authorities to address such factors at a local level, Councillor Devenish states that:

*'And we are more local, I think, than the NHS, with the greatest respect to them.'*

**Cllr Anthony Devenish**

Cabinet Member for Public Health and Premises, Westminster City Council

This suggests there is something inherently more ‘local’ about local authorities in comparison to PCTs, which were local organisations but subject to national control as part of the NHS.

While most contributors welcomed the opportunity for greater freedom for public health from central interference, there was a recognition including from professional groups, that certain public health outcomes required national co-ordination to address, and that doing so may require public health professionals to reconcile centrally determined policies and targets with the “localism” agenda:

*‘Despite the rhetoric of localism, many shadow boards [HWBs] are concerned that national policy imperatives will over-ride locally agreed priorities and are uncertain about the extent to which they can influence decisions of the NHS Commissioning Board\*. Roles and responsibilities of all new bodies need to be defined much more clearly.’*

**King’s Fund**  
Written submission

*‘It is important that local areas are given autonomy to allocate their resources according to local priorities, whilst recognising the tension between the localism agenda and the need for national priorities to be resourced and addressed.’*

**UKFPH**  
Written submission

It was felt that some national strategic priorities may over-ride local imperatives, which may themselves be subject to regular change with the electoral cycle. Through the creation of the Public Health Outcomes Framework (PHOF), the HSCA12 does contain some “prescriptive” elements whereby the Department of Health is able to influence the priorities of local public health agencies. The PHOF outlines key national indicators which Local authorities must work towards achieving. This move was welcomed by Professor Chris Bentley:

*‘While Localism requires the setting of locally relevant outcomes, there is encouragement that where appropriate these should contribute to National Outcomes also. These are set out in the three National Outcome Frameworks.’*

**Professor Chris Bentley**  
Independent Population Health Consultant

\* NHS Commissioning Board has been renamed NHS England since the Select Committee report was written

Regardless of how the challenge of addressing national priorities is addressed, it was seen as possible that the process of localism, with the devolution of roles and responsibilities, could lead to increased variance between local areas in the way in which public health is delivered:

*'The District Councils Network (DCN) recognises that, by its very nature, localism inevitably leads to a variation in local responses and has the potential to encourage innovative local solutions'*

**DCN**

Written statement

*'The Government have been very explicit that they will be taking as many hands off as they can in terms of how that is organised locally, so it is not surprising there will be quite a lot of variation. The promise is that there will be more innovation and maybe variation in services and how people work and so on, but less variation in outcomes and fewer inequalities'*

**David Buck**

Senior Fellow, Public Health and Inequalities, The King's Fund

Despite the commitment to maintain outcomes, there was concern that this will be more difficult to ensure in a decentralised system:

*'The concern is that outcomes start to drift. Duncan and the Government have been very clear that Public Health England is not a performance manager in the way the Department of Health used to be, and sector-led improvement is the way to go, but I do have some concerns about how we support the real tail of possible poor performance. That may come about because of greater localism. That is an obvious risk of localism, but there are many benefits as well.'*

**David Buck**

Senior Fellow, Public Health and Inequalities, The King's Fund

## **Accountability**

As mentioned above, contributors to the report mainly used the term "localism" to describe the reduced interference by central Government which would occur following the reforms. There was less discussion, particularly amongst local and national politicians, about what new forms of accountability may be required to replace this form of scrutiny. In the previous system, accountability was primarily to other structures within the NHS whereas now public health officials are principally accountable to the local authority and its wider electorate. It was acknowledged that working in a political environment may change the nature of the accountability being delivered:

*'That means directors of public health and public health specialists going into local government are going to be in an environment they are not familiar with; there will be political leadership in a direct way that they are not familiar with. The opportunities will be immense, but they will be more accountable than they have ever been before. It will not be a matter of reporting what is not right; it will be about, "What are you doing to help make it right?" This is a very different ask.'*

**Duncan Selbie**

Chief Executive designate, Public Health England

In addition to changing the way in which progress and outcomes are described and delivered, it was suggested that the nature of working within a local authority may mean that some public health priorities could not be pursued due to a lack of political will. Concern was expressed about how clear accountability can work in such as setting:

*'There will be things on which I and perhaps others feel strongly where in the politics we lose the battle. As well as being rosy and very optimistic about the opportunities, there will be places where the opportunities are not realised and things go in the opposite direction. We do need to ask ourselves how we intervene and hold people to account in those circumstances.'*

**Dr Nicholas Hicks**

Programme Director for Public Health to the NHS Commissioning Board

There was disagreement regarding the robustness of accountability mechanisms within the new system. Generally, public health and healthcare professionals expressed concerns:

*'I am concerned about the accountability issue. I am not clear how people who are not getting good public health services and function delivered, and whose local authority is not matching up to their future legal duty to improve health, will be dealt with'*

**Professor Gabriel Scally**

Director of WHO Collaborating Centre for Healthy Urban Environments

*'Alongside the issue of funding is accountability. It is unclear to whom HWBs are accountable. Government states that they will be accountable to local people through having local councillors as members of the board who are accountable through election. The RCN does not believe this is adequate.'*

**RCN**

Written submission

Concerns about these mechanisms were not unanimous however. In general, local authority representatives were more positive about integrating their work with a public health agenda, and doing so in an accountable way:

*‘There are clear accountability mechanisms in place; I am not saying we should not be held accountable. Things like health scrutiny and Healthwatch are going to be very important in keeping some local temperature in the relationships between health and wellbeing boards and the wider public. There will be the lens of the media. There are very strong levers that will hold us to account and so there should be.’*

**Cllr Steve Bedser**

Chair, Community Wellbeing Board, Local Government Association

*‘Accountability is more than just a “vertical” relationship—it is about working collaboratively, persuading, negotiating, championing and advocating.’*

**Newcastle City Council**

Written submission

Finally, the UK Faculty of Public Health emphasised in their submission that local authorities themselves must change to become accountable both for the allocation and spending of public health funds but also for ensuring that, across the range of local authority services, they are seen to be addressing the social determinants of health:

*‘Local authorities should be held to account for the public health funding that will be disbursed to them by PHE and made explicitly accountable for the delivery of an agenda through commissioning, policy and management that addresses the social determinants of health.’*

**UKFPH**

Written submission

## **Funding**

To enable the transition of the public health workforce into local authorities, the Department of Health made a commitment to initially ‘ring-fence’ public health funds within local authorities. With the changes occurring at a time of public spending cuts, the ring-fencing of funds was designed to “protect investment in the fledgling public health system” (CLG Select Committee, 2013, p.70). This was concerning to some, particularly to local authority representatives, for whom it seemed to run counter to the expressed “localism” rhetoric of the reforms. This potential conflict was expressed by one of the CLG Committee MPs, in addition to a representative of the King’s Fund:

*'Ring-fences in our opinion are less appropriate when you expect and want more localism and innovation, so you want variation. It is the outcomes you are interested in that are really important, not how you get to them, and you expect local areas to deliver them in the way that is fit for them with no specific configuration of services.'*

**David Buck**

Senior Fellow, Public Health and Inequalities, The King's Fund

*'I do not favour ring-fenced budgets. If councils and health and wellbeing boards have set very clear, strategic objectives with a common view about how best to achieve it, then that is an appropriate way to spend money. Ring-fencing may create barriers where they need not exist.'*

**Cllr Alan Connett**

Executive Lead for Health and Wellbeing, District Councils Network

By contrast, most public health professionals were supportive of the ring-fence, at least in the short-term, with the expectation that public health professionals would be able to justify their worth sufficient to secure ongoing funding at an appropriate level:

*'We need a ring-fenced budget protected for the foreseeable future, perhaps an expanded one, and one in that great future with local authorities recognising the value of health, we will have a much bigger ring-fence created by local authorities.'*

**Dr John Middleton**

Vice-President, UK Faculty of Public Health

Due to the broad definition of public health, there was a concern amongst professionals that without a robust ring-fence money could be:

*'purloined for other, probably well meaning causes, but at the expense of public health.'*

**Dr Peter Carter**

Chief Executive, Royal College of Nursing

## **Authorities and responsibilities**

Much of the discussion relating to this concerned the role of Director of Public Health (DPH) who is the individual within the local authority co-ordinating and leading on public health issues. Their fundamental duties are set out in law but how these translate into everyday practice depends on a range of factors, shaped by local needs and priorities (DoH, 2012b). Verbal and written evidence in the report raised interesting discussions around issues of authority, autonomy, and how best to exert influence in a local authority (as opposed to an NHS) setting.

i) Authority

New public health posts and organisations have been created by these reforms. Roles and responsibilities of existing structures have also changed. There was recognition from witnesses that there was the potential for tension between the roles of different agencies, particularly between staff from NHS and local authority backgrounds. Public health professionals expressed concern about the possibility that the role of DPH may be marginalised within local authorities.

*'In moving into local authorities, they won't know what they don't know, and the need for the senior public health person to be at the chief officer's table reporting to the chief executive is absolutely essential. Directors of Public Health need standards, resources and powers. One of the aspects of these reforms that worries me and some of my colleagues is the notion of assurance—that we will somehow float over the whole system and say it is all okay. Is it a warm glow you feel when the hospital tells you it is doing the right thing, or is it a critical inspection of what is going on, be it in infection control, screening or any of the other areas? To me, it feels that Directors of Public Health need to have both the resource and the power to deliver those.'*

**Dr John Middleton**

Vice-President, UK Faculty of Public Health

*'This is one illustration of why it is so important that the Director of Public Health does have a place at the top table and that direct accountability, not only so their advice is taken seriously and they maintain their independence and credibility, but also so they can work right across the local authority and give that kind of advice on a sound basis.'*

**Dr Penelope Toff**

Co-Chair, Public Health Medicine Committee, BMA

Being located in the upper tiers of local authority hierarchy was therefore seen as important to allow the DPH to ensure that public health activity/ethos is fostered throughout the local authority. The status which comes from being “at the top table” is important to achieve this, at least initially. As the above quotes suggest, this was a key consideration of public health professionals. However, the views were also endorsed by the Government spokesperson, Baroness Hanham:

*'...the director of public health has got to be at the top of the tree and able to direct or advise on all the other aspects of local government. He is going to take in housing, social services, education, waste and all the rest of it. He has to be in a position where people listen because he is at such a level that they cannot ignore him. We hope and expect that all local authorities will have the director of public health at the second tier under the chief executive, at the very least.'*

**Baroness Hanham CBE**

Parliamentary Under Secretary of State, Department for Communities and Local Government

Even at the time of the committee hearings (November 2012 - January 2013), there were concerns expressed that the role of DPH was not being prioritised within some local authorities:

*'My concerns about the transfer relate to the power and influence of the director of public health and his or her team, and their station within local authorities. We will see of course when it actually happens on 1 April where the location is, but I hear far too many reports of directors of public health potentially ending up as third in line, reporting to other directors, such as directors of adult social care, and being seen as part of that. Some directors of adult social care are making a very deliberate play to take over public health. After all, it is all about wellbeing, is it not?'*

**Professor Gabriel Scally**

Director of WHO Collaborating Centre for Healthy Urban Environments

ii) Autonomy

Some witnesses identified the importance of a DPH's professional autonomy within a local authority given that the potential exists for local public health priorities to conflict with local political objectives. One contributor gave the hypothetical example of a tobacco factory in a local authority providing jobs but representing a significant problem to public health professionals:

*'What if you had a community where the main source of income was a tobacco factory, and the health and wellbeing board came up with fantastic tobacco control plans? One can imagine the scenario where people are voted in by those whose livelihoods depend on tobacco sales. In that community perhaps the money was disappearing and substance misuse services disappeared. It is worth asking ourselves: what is the protection for people in those sorts of areas?'*

**Dr Nicholas Hicks**

Programme Director for Public Health to the NHS Commissioning Board

Professional agencies such as the Royal College of Nursing (RCN), felt that the autonomy of the DPH must be safeguarded to ensure their independence in such situations where they are required to directly challenge the local authority:

*'DPHs have a professional responsibility to produce an honest and unbiased annual report. Correspondingly, they should have the professional independence to speak out on public health issues within their area. The DPHs should be supported and empowered by their employing local authority to carry out all public health duties necessary.'*

**RCN**

Written submission



By contrast, concern was expressed by local authority representatives that there may need to be limits on the power and autonomy of public health staff in order to preserve the political agenda of the council:

*'A balance will need to be struck between maintaining the independence of public health officials, whilst ensuring that the political leadership of the council is not constricted.'*

**Westminster City Council**

Written submission

iii) Exerting influence

In addition to the authority of public health staff within the system, the processes of attracting and exerting influence for public health are **also** likely to be different in a local authority setting compared to a healthcare setting:

*'To be an effective influencer you need a platform of power, and that comes in a variety of different forms: your own personal attributes; your professional and technical skills and knowledge; but you also need managerial power and an ability to deliver your home organisation... I do not think you can do that if you are third tier or seen as someone below it with the same status as a corporate director. If you have got corporate directors and somebody else sitting below them, they know you do not run the organisation—game over.'*

**Nicholas Hicks**

Programme Director for Public Health to the NHS Commissioning Board

Given the number of new organisations being formed as a result of the reforms, it was suggested that local authorities may be best placed to initially demonstrate leadership and exert power within the public health system:

*'Now, I think you have to be very careful, because everything that we are talking about in this should be about shared leadership, and there is a very easy temptation, perhaps particularly for bodies like ours, to be a bit directive. I think we have to guard against that extremely carefully. But it is natural, I think, just given the shaping of the organisations, because if you look at who is round the table on a Health and Wellbeing Board, CCGs have come into being over the last year or two and are, in the case of Kent, still going through their authorisation process. Healthwatch is still in the process of coming into being, etc, etc. So in many ways I think it is natural that the local authority will take quite an active role in all this. Over time, as some of the other organisations mature, that may well be shared a bit more.'*

**Cllr Roger Gough**

Member for Business Strategy, Performance and Health Reform, Kent County Council

Bearing this in mind, there was recognition that new structures such as Health and Wellbeing Boards (established as formal sub-committees of top-tier and unitary authorities), need to have power intentionally vested on them if they are to successfully integrate NHS services with public health and social care, as envisioned by the reforms:

*'It is also vital that they should not become just "talking shops", but are instead given powers to hold to account robustly all of the various stakeholders across the fragmented health and social care system.'*

**British Medical Association (BMA) - in reference to HWBs**

Written submission

Public health staff also have a responsibility within the new system to collaborate across local authority departments in a way which increases the profile and effectiveness of public health projects:

*'Your aim is to get the whole of the health service budget and local government budget, plus the organisations beyond, used in a way that supports and promotes health and reduces inequalities.'*

**Dr Nicholas Hicks**

Programme Director for Public Health to the NHS Commissioning Board

## RELATIONSHIPS

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The relocation of a significant proportion of the public health workforce into local authorities meant that public health staff would need to develop new skills and new relationships in order to work effectively in the new environment. The Department of Health acknowledged this in a briefing paper which described how public health professionals and local authorities must work together “*to plan and build the local relationships and partnerships that will be key to implementing the new public health system*” (DoH, 2011b, p.4)

Prof. Bentley, an independent public health specialist, outlined this point to the Committee:

*‘The issue about the whole health and wellbeing strategy that we have all been talking about in the last week or so is: “What levers does it bring with it?” There are not that many. What you are doing is setting up a structure that then relies on the people within that structure to make it work. It does not bring powers. What it does potentially bring is relationships. That is what you are relying on: you are relying on the fact that those relationships, bringing people into the same place, giving them the same information and having the discussion, allows them to agree things together, which they can then take out to their separate places, either districts or organisations, and say, “Yes, we are all agreed on this. This is what we need to do in our particular place or organisation.” That is okay, but of course it depends on the quality of leadership and relationship, which brings more patchiness into the system. When it works well, it works; but when it is not there, you’re stuffed.’*

**Professor Chris Bentley**

Independent Population Health Consultant

The new roles require public health staff to *integrate* within existing local authority structures. At the same time, they need to be able to *collaborate* with a host of different organisations, many of whom they will not have dealt with previously.

### Integration

i) Role of Health and Wellbeing Boards

Of all the new structures created during the reforms, the Health and Wellbeing Board (HWBs) received most attention in the Committee hearings and its report. Unitary and top tier local authorities have a statutory obligation to establish these Boards, which are expected to “oversee local commissioning, and health and social care integration” (CLG Select Committee, 2013, p6]\*.

\* For further details on the role and remit of HWBs see Coleman et al., 2014.

According to the King's Fund (King's Fund, 2012), the establishment of HWBs had been "almost universally welcomed". Despite this, witnesses did suggest potential challenges HWBs will face when seeking to improve integration of services, including in larger or multi-tiered authorities:

*'HWBs will play a key role in facilitating integration and co-operation. However, if boards are too big, meaningful discussion and decision-making becomes difficult. If boards are too small, the views of appropriate representatives will not be heard and challenges will not be appropriately understood and acted on. Partnership working arrangements will, therefore, be tested more in larger local authority areas, with second tier district councils, urban and rural areas and potentially several CCGs to include'*

**RCN**

Written submission

Nevertheless, it was thought that there would be potential for patients to benefit from better integration between health and social care. Examples of this would relate to palliative care, as described in the submission from the Sue Ryder Care charity, and working with troubled families, as outlined by Prof. Bentley:

*'Best practice examples of integration initiatives illustrate the importance of key relationships and individual leadership. This has meant that innovative service design has generally been specific to local context. The new HWBs provide the opportunity for integrated planning to be stimulated and a consistent approach adopted across the country. We hope they will establish the right mechanisms which will make integrated working a reality and improve the lives of people with complex needs and those at the end of life.'*

**Sue Ryder Care**

Written submission

*'There is a lot to be gained from that way, and there is a lot to be gained from the working-together component, with which the Health and Wellbeing Boards should really help. That is one of the real pros of Health and Wellbeing Boards. Things like integrated care services and things like single infrastructures working into communities, where at the moment we have a whole plethora of them, all separately funded and adding up to chaos rather than a smooth interaction with communities.'*

**Professor Chris Bentley**

Independent Population Health Consultant

In order to deliver this degree of integration, public health individuals and structures, - including HWBs - must develop strong relationships across the local authority. Public health staff may initially be unfamiliar with local authority structures but they will be expected to work alongside, and influence, representatives across all levels of the authority, from the Executive Officers to members of District Councils:

*'As to success so far, some research has recently been carried out, which we released on Monday, indicating that most health and wellbeing boards were structurally being set up reasonably well. The issue is about how health and wellbeing boards co-ordinate with their respective councils at the top tier of local government and how they are engaging with district councils below that. We are starting to see parallel structures being created with local health and wellbeing boards and local JSNAs. They are starting to tease out the issues within local government.'*

**Graham Jukes**

Chief Executive, The Chartered Institute of Environmental Health

ii) Conflicts of interest

It was noted that the process of integrating CCG representatives with public health staff and local authority representatives within HWBs, had the potential to generate conflicts of interest. For example, the expressed intention of HWBs is to foster integration of services, yet they are also tasked with providing strategic direction to the commissioning activities of local CCGs (whose members sit on the HWB). In addition, HWBs were given responsibility for overseeing their local submission for the "Better Care Fund" in 2014. The Better Care Fund is an NHS England initiative focused on improving integration of health and social care (NHS England, 2014). The latest guidance places emphasis on reducing unplanned admissions (NHS England, 2014), which will require HWBs to collaborate closely with CCGs, holding them to account where necessary. These competing roles have the potential to generate tension:

*'Boards need to be clear about what they want to achieve. We found potential tensions between their role in overseeing commissioning and in promoting integration across public health, local government, the local NHS and the third sector.'*

**King's Fund**

Written submission

However, at the time of the Committee hearing, the extent of the conflict of interest was unclear since:

*'The precise way in which the DPH is expected to hold other public health agencies to account without either the commissioning budget or formal managerial authority, is not clear.'*

**Sheffield City Council**

Written submission

Establishing this is important to the building of trust and relationships between fellow members of the HWB. Nevertheless, given the nature of the different agencies contributing to HWBs, the Chief Executive Designate of PHE made clear that HWBs will not be able to eliminate all potential conflicts of interest:

*'That is the point. If you say you cannot be involved because you might be conflicted, it means that 90% of the folk cannot be in the room.'*

**Duncan Selbie**

Chief Executive designate, Public Health England

iii) Boundary-spanning issues

HWBs serve as the model for promoting integration within their defined geographical areas, which mirror upper-tier / unitary local authority areas. Local authorities often cover a larger geographical area than their corresponding CCG, resulting in HWBs having member representatives from more than one CCG. As an example, Kent County Council has 7 CCGs and in order to address the challenge this posed to integrated working, Kent County Council established local non-statutory HWBs which followed CCG boundaries (Kent County Council submission). In doing this, it was able to draw on the expertise of its district council representatives. To note, District councils form a lower tier of representation in 27 two-tiered local authorities and are overseen by county councils who have the statutory responsibility to establish HWBs (CLG Select Committee, 2013). District Councils were not given an explicit role in the public health system reforms.

In addition, it was suggested that some public health problems span the boundaries of individual HWBs. It may be necessary therefore, to allow a degree of integration between neighbouring HWBs, for example:

*'I worry to a certain extent about how different health and wellbeing boards relate to each other. We are very concerned as a profession about how you deal with the larger than local considerations in local government as a whole. If I give a theoretical example: if you have an area where chronic overcrowding is a problem and you have not got the land within your area to sort that out, and you are a unitary authority or a county, how do you then influence the health and wellbeing strategies of the neighbouring area and its board? That is possibly an issue over neighbourliness and over space, which may not have perhaps been the focus of other people's evidence before you. I think it is a very important question, and one where my members are going to feel that there is a need for some kind of mechanism for the cross-boundary health and wellbeing board issues to be considered.'*

**Richard Blyth**

Head of Policy and Practice, Royal Town Planning Institute

These considerations also extend to sharing best-practice between local authority areas. The quote below outlines an ethical imperative for integration between HWBs but also a pragmatic one since this process can generally help to improve standards:

*'If I as a local authority officer find that the neighbours are not doing as well as they need to on TB, genitourinary medicine or drug control, those problems are my problems too. If I have a wonderful town planning service that does safe walking and cycling and those routes stop at the border, we will not get the best for public health, so we need standards across authorities.'*

**Dr John Middleton**

Vice-President, UK Faculty of Public Health

## Collaboration

In order for policy goals to be achieved, it is clear from the report and expert witnesses that public health professionals (and HWBs) need to develop strong working relationships, both within their local authorities and with a range of external agencies. However, in order to be successful, the Committee heard many testimonies of the importance of collaboration between public health professionals (and HWBs) with a range of external agencies. These included:

i) NHS structures

CCG representatives are full members of the HWB and are thus required to attend and contribute to their meetings. By contrast, CCGs are not obliged to invite local authority representatives to their meetings.

There has been recognition that the movement of public health staff away from the health service has the potential to change the nature of services commissioned by CCGs. It is expected that HWBs will influence the commissioning agenda, particularly in relation to public health. However, the nature of the relationship between CCGs and HWBs had not been made explicit, leading to a degree of confusion amongst some CCG members:

*'We had an interesting discussion in one of the places I was working with where we had reached the point where we had decided some priorities, and then the CCG said, "So are you saying that the Health and Wellbeing Board is going to tell us what to do? We have been deciding what our plans are going to be. Are you saying that the Health and Wellbeing Board is going to tell us what to do?" I said, "The Health and Wellbeing Board 'R' Us." You are the Health and Wellbeing Board. You are a core part of it. It is not telling you what to do. You*

*should be, as a group of people, making joint decisions and then taking away the findings to implement them. It is not a question of one person telling another what to do ‘*

**Professor Chris Bentley**

Independent Population Health Consultant

This quote highlights the possible challenges that CCG representatives may face in working with HWBs, whose membership is expected to influence commissioning decisions and oversee delivery of the Better Care Fund. The degree to which CCG representatives are able to work collaboratively with HWBs will be dependent upon strong, accountable relationships forming from the outset.

One barrier to such effective collaboration exists between HWBs and CCGs in areas where their boundaries are not contiguous. This requires HWBs to make judgements about the core membership of their team:

*‘It is an observation, and Alan I were talking about this before we came to give evidence. I will leave Alan to speak for himself on behalf of district councils, because it is not a world I directly inherit. All health and wellbeing boards will inherit a degree of complexity. In my own situation we have got devolved structures that have given us 10 districts and four clinical commissioning groups. I am chair of the health and wellbeing board, and if we had everybody who wanted to be around that table, we would be holding our meetings in a stadium rather than a committee room.’*

**Cllr Steve Bedser**

Chair, Community Wellbeing Board, Local Government Association

However, examples were given where strong relationships had already been made across a number of HWBs:

*‘it feels different. There is more focus and there is more of a sense of commonality, say, between CCG members and councillors in the health and wellbeing boards that I see, not just in Oldham but in the perhaps 18 or 19 others I am working in as well. So I am optimistic despite the evidence of history.’*

**Liam Hughes**

Independent Chair, Oldham shadow Health and Wellbeing Board

HWBs will also need to work with NHS England (previously NHS Commissioning Board). This is the body responsible for overseeing commissioning processes nationally, in addition to having specific responsibilities for commissioning around 145 specialist services. Although NHS England is responsible for the performance management of CCGs, it was suggested that in the new system, they would also be expected to play a more collaborative role within HWBs, which may require representatives to adopt a new approach:



*‘One of the members of the Health and Wellbeing Board will be someone from the LAT, the Local Area Team, of the NHS Commissioning Board. The question is how they then play it—whether they see themselves as an inspector sitting there watching what is going on and being judgmental, or whether they will pitch in there’*

**Professor Chris Bentley**

Independent Population Health Consultant

ii) Local authority departments

The nature of public health means that there will be local authority departments (e.g. housing, leisure, planning) which are not directly involved in the reforms or mandated to attend the HWB meetings, but which nevertheless feel that there is synergy between aspects of their remit and that of the public health team. These new collaborations may require imagination and new skills but have the potential to benefit some of the key public health outcome areas:

*‘An important objective is to make the most of the impact that Public Health can have by being part of the local authority. This has been achieved through close working with County Council departments, examples include the library health and wellbeing offer, wellbeing Wednesdays, substance misuse in young people, healthy schools, teenage pregnancy, active travel.’*

**Leicestershire County Council**

Written submission

*‘The reason we chose housing [to have a permanent seat on HWB] is because we think it is so fundamental to health that we need a direct link in to the Cabinet Member and the housing services that his portfolio provides. That is how we have made up the Board’*

**Cllr Mary Lea**

Cabinet Member for Health, Care and Independent Living, Sheffield City Council

In addition, the role of individual Councillors and how they can best be engaged was also considered. There is the potential for HWBs to provide a setting where GPs and Councillors can directly meet and share experience and best practice:

*‘Boards are developing a common language and are beginning to provide a common strategic framework and a shared culture for local stakeholders. Lead GPs and councillors, in particular, are learning about each other, and discovering that they have common experiences and aspirations—they work for long periods at the sharp end of things in*

*particular neighbourhoods, they have local information about needs and assets, and they see at first hand the effects of social and economic change and the impact of national policy.'*

**Liam Hughes**

Independent Chair, Oldham shadow Health and Wellbeing Board

David Buck, from the King's Fund, echoed these sentiments, although highlighted the importance of engaging all Councillors within a local authority, not simply those represented on the HWB:

*'It also particularly opens up opportunities for good conversations and joint working between GPs and local councils, which has often been hard in the past. Both of them come from a space where they are talking about small areas—their wards and patches... That conversation between the NHS and councillors has often been difficult before, because it has been primarily a relationship between the PCT, a much higher-level body, and local councillors. There are some real opportunities, particularly with GPs and local councillors as they come to the health and wellbeing board, through the CCG role. It is a good question about the average councillor. The councillors I see are the ones who are enthused, not the ones outside the health and wellbeing board remit, so it is a good challenge and good question to us.'*

**David Buck**

Senior Fellow, Public Health and Inequalities, The King's Fund

iii) External agencies

In addition to bringing together the key commissioning partners, HWBs are expected to consider the role of other agencies, such as local charities or private businesses involved in local health and wellbeing. Their challenge is to go beyond consulting such organisations to creating a climate whereby they can “facilitate active engagement” [below] by these groups:

*'The implementation challenge includes building robust partnership working within Health and Wellbeing Boards between a wide range of public private and voluntary organisations, and strengthening the leadership role of local government as an orchestrator of these inter-organisational partnerships. This is not to suggest a dominant role for local government, but to capitalise on its role as a democratically elected body to act as the leader of the orchestra of different players facilitating active engagement by the public, the NHS and other public services, and the private, voluntary and informal community sectors'*

**Dr Mike Grady**

Principal Adviser, University College London Institute of Health Equity

iv) Government

Finally, it was acknowledged that some aspects of health promotion require national-level co-ordination and policy. It was argued that public health would benefit from the political influence and skills of local authority staff when seeking to petition central Government on such matters:

*'Using local accountability and expertise to influence Governments and partner organisations for example on issues such as major food and consumer issues, alcohol pricing, spatial planning, which have a direct impact on public health'*

**Sheffield City Council**  
Written submission

## **Workforce issues**

i) Staff transfer

Many contributors acknowledged that the transition from working within the NHS to local authorities would present challenges to public health staff. This had the potential to cause uncertainty amongst the existing workforce:

*'I have to recognise the personal uncertainty and, for some, trauma of the extended period of time, but it is getting to a point where certainty is starting to come into the system. About half of the workforce as we have conventionally understood it are moving into local government. For some weeks there has been an agreement in place about the transfer of staff; 152 authorities have just done a self-audit and the LGA can talk themselves about what they have discovered. But broadly it is positive. It is a period of transition and uncertainty, but it should begin to settle.'*

**Duncan Selbie**  
Chief Executive designate, Public Health England

Significantly, this issue was also identified by local authority representatives:

*'there are issues around needing to instil confidence in people who are transferring from the NHS to local authorities that public health is treated seriously across the board and not just by those local authorities that are saying that they are treating it seriously.'*

**Cllr Nick Forbes**  
Leader, Newcastle-upon-Tyne City Council

Regardless of how well these challenges are addressed, there was recognition that some loss of skilled staff, particularly at senior levels, was to be expected:

*‘Every time we go through one of these major reorganisations, we lose about 30% of our senior people in public health, so there are going to be some deficits in staffing’*

**Professor Gabriel Scally**

Director of WHO Collaborating Centre for Healthy Urban Environments

Some of this anxiety specifically related to issues of terms and conditions and whether contractual obligations would be met in the new system:

*‘I agree with John that there is a lot of anxiety and discomfort, and it is not just about the period up to the transfer. If you look at my crew, they would accept there is a TUPE transfer process that will take them in, but they do not know what is going to happen beyond that. They are anxious about that and what it means, not so much regarding the content of their work but their terms and conditions and what will happen there, and given that no one can give them a straight answer at the moment, you can understand why.’*

**Dr Nicholas Hicks**

Programme Director for Public Health to the NHS Commissioning Board

It was felt by some that such contractual issues could lead to a further attrition of skilled workers if appropriate assurances about contractual issues were not given, including to public health departments out-with local authorities, such as Public Health England:

*‘The biggest issue for us is that, by transferring across, we want to make sure there is not a brain drain and people with skills feel disinclined to come across. Particularly in relation to nursing staff, we need to ensure there is parity in terms of pay, pensions, and terms and conditions’*

**Dr Peter Carter**

Chief Executive, Royal College of Nursing

*‘One way to counter this potential fragmentation is for there to be a unified set of terms and conditions, including pension rights, for those working in the new health service—whether they are based in local government, the civil service or the NHS. A failure to offer such equitable terms and conditions will undoubtedly lead to local authorities not being able to recruit the best public health doctors, who will instead seek jobs in Public Health England (PHE), CCGs the NHS Commissioning Board, or outside the publicly funded health service.’*

**BMA**

Written submission

In addition to these issues, addressing a knowledge deficit about how local authorities operate was seen as vital to the successful transition of public health staff:

*'I just wanted to talk about culture and the change of culture that comes with entering local government. The LGA [Local Government Association] with the Department of Health ran a series of workshops for staff working in public health well before the transfer. At first, they did not know that much about how councils operated and they were very pleased to hear from leaders of councils, chief execs and others about that. There was a lightbulb moment when some of them realised that, even under these difficult times in local government, there are far more career opportunities in the local authority than there would be in a small public health department inside a PCT. I think that began to open up different sorts of discussions with those staff, because they bring a skill set that is about public health in the way Nick described it—in the very widest sense.'*

**Liam Hughes**

Independent Chair, Oldham shadow Health and Wellbeing Board

Stressing the positive benefits of working within local authorities was something Councillors were keen to communicate:

*'Intellectually, they might have thought this might be a good move for them, but I think their hearts are with the Health Service, because that is where most of them have been for most of their working life, so they have to make that shift. I think also we need to help them to look and discover the opportunities that are there within the local authority that you certainly would not have within the Health Service. As we have said before, the Council is a place-maker, if you like. We can gather people together. We can get all the organisations within the city. We can ask people to come together to discuss any problem we would like them to discuss and come up with solutions, and public health will have access to all that resource, which I do not think they have had in the Health Service. We have to help people understand those opportunities as well as help them through this difficult time.'*

**Cllr Mary Lea**

Cabinet Member for Health, Care and Independent Living, Sheffield City Council

Whilst being supported to adapt to the local authority setting, the King's Fund expressed concern that the skills of public health staff should also continue to be applied in clinical settings, perhaps in co-ordination with CCGs:

*'The move must also not isolate the skills and expertise that a large number of public health specialists have in clinical care and clinical service design. The support and intelligence that public health teams can offer to both clinical commissioning groups and local authorities will need to be carefully managed and resourced if it is to deliver the intended benefits. The right balance needs to be struck between ensuring that clinical commissioning groups don't over-rely on public health teams to deal with public health issues and health inequalities, and making sure that clinical commissioning groups don't break away from local public health*

*teams and duplicate their own public health functions internally, or fail to collaborate with their local authority partners.'*

**King's Fund**

However, this was seen as a potential difficulty where there may be insufficient staff to set up the collaborative relationships outlined above:

*'The transfer of public health professionals and practitioners into local authorities has been very variable, and some do not have the critical mass to do other than the minimalist "churning out" of an annual JSNA report. In some areas, the analytical capacity has been pooled, which may work, unless it results in "formulaic" product for its constituent areas, without the local capability to manipulate and use the analysis.'*

**Professor Chris Bentley**

Independent Population Health Consultant

Again, there was also concern from local authorities that an 'NHS-led' approach to the transition threatened to undermine the immediate benefits available from partnership working with local authorities:

*'The Department of Health's transition programme is perceived as taking a very NHS-led approach to the PH changes. It could have secured more active involvement of individual local authorities in the "design" of the new system. Moreover, there is a perception that the national focus has been on "protecting" NHS Public Health specialists and programmes rather than actively engaging and supporting local government—clearly, there does need to be support for NHS staff who are moving across to councils but this needs to be balanced alongside the potential opportunities for the future in terms of public health impact. The Local Government Association has tried to re-balance this perception and Public Health England has started to open up a dialogue with local government on these issues.'*

**Sheffield City Council**

Written submission

## ii) Training

There was widespread acknowledgement that new skills would be required to work in the more 'political' environment of a local authority. This was recognised by Councillors themselves - some of whom felt a responsibility for preparing public health staff to work in this setting:

*'I think there is a bit of a change in culture, because elected members have an opinion and they will give it. They will say, "These are our priorities," and maybe sometimes it will conflict with what they feel they have always done as health professionals. Obviously, we will*

*prepare them for that, but we do listen to advice, do we not? We do not ignore it, and we can be very helpful to them as well, as local members—extremely helpful to them'*

**Cllr Mary Lea**

Cabinet Member for Health, Care and Independent Living, Sheffield City Council

The anticipated loss of senior leadership also suggests that there could be a deficit of public health staff with strong leadership skills necessary to making a successful transition to the new system:

*'There is likely to be a shortage of experienced senior public health staff, and whilst a start has been made in preparing the next generation of leaders, more needs to be done—not least because their new home in local government requires even greater skills in working in a political environment, and brokering inter-sectorial alliances. The Local Government Association and the Faculty for Public Health have worked together to find solutions to some (but not all) of the dilemmas associated with the transfer of staff, and the LGA has run an extensive orientation programme for public health teams.'*

**Liam Hughes**

Independent Chair, Oldham shadow Health and Wellbeing Board

In addition to training of public health specialists, there was also a suggestion that other local authority representatives would benefit from education regarding the nature and remit of public health activities:

*'I know, as a director of public health, if I am having discussions with transport officials or leisure services officials, it is so much easier if they understand what public health is about in the first place. So I think there should be more widely spread public health skills.'*

**Professor Gabriel Scally**

Director of WHO Collaborating Centre for Healthy Urban Environments

## PUBLIC HEALTH ACTIVITY

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All those who contributed evidence to the Select Committee acknowledged the significant nature of the changes being made and the reforms themselves were generally welcomed. Most contributors recognised that social determinants of health could be better tackled in a local authority setting than within the NHS, which is orientated around healthcare delivery. In order for the reforms to work, it was suggested that public health staff may have to adapt their workload and priorities in order to reflect this new way of working.

### Defining public health

Successful engagement of local authority staff was seen as critical to the success of these reforms. Much evidence submitted to the Committee suggested real enthusiasm about the reforms. This was rooted in a perception that much of the existing workload of local authorities could be conceptualised as “public health” in character. The full integration of public health professionals within local authorities was therefore viewed as essential by local authority representatives. It was generally felt that this must go beyond involvement with the HWB and creation of the JSNA, and that public health staff (particularly the DPH), should be able to influence the wider agenda of local authorities:

*‘I think at the heart of that question is the fundamental issue about what the role of public health staff is and who public health professionals are. I consider myself, as Leader of the Council, to be a public health professional because, to me, public health is about improving the quality of life for everybody. I think the role of public health specialists who are transferring is to enable a wider discussion about the things that local authorities can do that will make a bigger difference. That is a crucial point about the integration of public health into local authorities: it is not about a stand-alone department that will come and sit alongside everything else’*

**Cllr Nick Forbes**

Leader, Newcastle-upon-Tyne City Council

However, there were concerns that not all Councillors may conceptualise public health in this way:

*‘When I spoke before I said that if we can get councillors to put health at the heart of their purpose, that is a great prize, and it is, but it is an “if”. There is still a risk that too many people see public health as just preventive services, health improvement or health protection and do not necessarily see the whole of the strategic content. One of the tests is looking at an existing council plan, which sets out the council’s ambition, and asking whether it wants the health and wellbeing board to help them deliver that plan, or whether they see the arrival of their leadership role for health as changing the council plan, so the council plan becomes much more focussed on health as a whole... For me, one of the key tests of your*



*question is: does the council really get its role as being the leader and responsible body for health in its community?'*

**Dr Nicholas Hicks**

Programme Director for Public Health to the NHS Commissioning Board

## **New ways of working**

Relocating public health into local authorities was thought to lead to many opportunities. In addition to those already outlined, there was a consensus that the general environment within local authorities could be more conducive to public health messages, particularly relating to health promotion, than was the NHS:

*'In relation to the DPHs, I think they will flourish in local authorities. They have nothing to fear from working with councillors; councillors care about their local populations. That was never an attribute that I saw universally displayed in the executive offices of the NHS. My advice to DPHs has been that they should love their councillors, and my advice to councillors has been that they should love their DPH. '*

**Professor Gabriel Scally**

Director of WHO Collaborating Centre for Healthy Urban Environments

One specific difference compared to the NHS is that local authority representatives may be more likely to conceptualise public health in terms of wellbeing and health promotion. In contrast, there was concern that the existing public health model being inherited by local authorities was too focused on disease management, rather than prevention:

*'There is a fundamental issue here about the balance of power between CCGs and providers within the NHS. The gravitational pull of the big foundation trusts is such that, if you look at the allocation of resources between prevention and treatment, you see it is almost all skewed towards treatment within the NHS. I would question whether many of the public health resources that we are thinking about inheriting in the future are fit for purpose.'*

**Cllr Nick Forbes**

Leader, Newcastle-upon-Tyne City Council

Such a definition could also influence the types of public health interventions Councillors may prefer. Again, public health staff will need to be mindful of this, particularly given that they still have ongoing health protection responsibilities which local authority representatives may not fully understand.

*'There are naturally questions about the ability of DPHs to remain neutral commentators on public health whilst employed within a political environment. This will undoubtedly be a challenge for all DPHs, especially when faced with current financial climate and Elected Members potentially favouring "non-traditional" or "non-medical" public health interventions which address the wider determinants of health.'*

**Sheffield City Council**

Written submission

## **Social determinants of health**

Many of those giving evidence suggested that local authority staff have a greater sensitivity towards the social determinants of health than may be the case in the NHS, in part because much of their existing workload already overlaps with this area:

*'Similarly, it is right that local authorities should lead this new approach locally because of their democratic legitimacy, their public accountability and their knowledge of local conditions. These attributes make local authorities ideal leaders of a more determined population-wide effort to improve health and wellbeing and reduce health inequalities. Councillors will readily grasp the social injustice of differences in life expectancy and lives lived free of disability determined by wealth and where people live.'*

**Chartered Institute of Environmental Health**

Written submission

Some of the statutory powers invested in local authorities allow them to intervene directly to address public health concerns (e.g. through imposing licensing restrictions) in a way that PCTs previously, or CCGs currently, would not be able to do:

*'To give you one example, we have made sure that my portfolio does not just cover public health; it covers licensing as well, and clearly there are cross-cutting issues there. For example, on shisha pipe smoking, which is a big issue in central London, we want to make sure that we work with the community to ensure that we do alleviate those issues, because obviously smoking shisha is a lot worse than smoking normal cigarettes.'*

**Cllr Anthony Devenish**

Cabinet Member for Public Health and Premises, Westminster City Council

Bearing this in mind, it was suggested that HWBs should have their own specific health promotion agenda, discrete from the commissioning of health services led by the CCG, addressing social determinants:

*'It is vital that health and wellbeing boards are truly effective in shaping the wider determinants of health, and in promoting other services that impact on public health (eg land use planning, housing, green space and transport) and are not seen as a secondary body to CCGs who are commissioning services.'*

**Royal Town Planning Institute**

Written submission

## DISCUSSION AND RECOMMENDATIONS

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### Challenges

Several challenges were identified 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:

1. Localism versus national / regional priorities
2. Integration versus ring-fencing
3. Autonomy versus accountability

1. Localism versus national / regional priorities

The localism agenda describes a process of decentralisation which has been undertaken by the Coalition Government since coming to power in 2010. The term itself was used in different ways. For some contributors, such as the Department of Health, it mainly represented a structural change characterised by reduced “top-down” control from central Government. Local authority representatives tended to stress positive attributes such as the opportunities for public health staff to collaborate with other local authority departments in a way determined by community needs.

However, one aspect of the localism agenda which was not covered in the Committee hearings related to how public health functions within local authorities could be made more directly accountable to local communities. This was highlighted in the Select Committee summary report:

*‘The purpose of localism is not only to bring decision making closer to local people, but to make it accountable to local people. Locally, Health and Wellbeing Boards will be pivotal, but how and whether the Boards are accountable, apart from through the election of their councillor members, is unclear. Similarly, the accountability of Clinical Commissioning Groups and the NHS Commissioning Board, whose commissioning will have a significant impact on the health and wellbeing of local people, is opaque. The Government should clarify how all these bodies can be held to account locally for the decisions they take. Local accountability will encourage engagement, and we are concerned to ensure that these reforms do not end up the preserve of senior councillors, clinicians and chief officers’*

**Select Committee summary report**

This is acknowledged in the Government's response to the report (DoH, 2013), which suggests that the involvement of Healthwatch and Councillors on HWBs should foster accountability to local people. It also authorises HWBs to liaise with NHS England if they feel that a CCG is not respecting locally agreed public health policy aims as set out in JSNAs and JHWSs.

Whilst the relocation of public health to local authorities was generally welcomed, there was debate about the authority and responsibilities of public health staff within local authorities. Through the establishment of the Public Health Outcomes Framework, the HSCA12 acknowledges that certain public health issues must be addressed across local authority areas, although flexibility remains regarding the processes used to address these. This was acknowledged in the summary report of the Select Committee which highlighted that specific aspects of health promotion may require legislation and oversight at a national level:

*'Some public health issues, such as alcohol misuse and obesity, may require central Government leadership and action, including legislation, if a big difference is to be made to the health of local people. Central Government action will not be a panacea, but to effect change local authorities may require the support of complementary national-level initiatives to make the most of their own strategies, powers and influence.'*

**Select Committee report summary**

## 2. Integration versus Ring-fencing

HWBs were broadly welcomed as having the potential to foster integrated working between health care, social care and public health. Their mandated membership necessitates that a diverse mix of stakeholders are consulted in the strategic and policy tasks of key commissioners in the HWBs. Such integration did not occur in the previous system when regional public health professionals were located within PCTs. It was pointed out that natural synergies exist in the workloads between many of these stakeholders, for example GPs and Councillors, in addition to shared knowledge of local community needs.

The opportunities for local authorities to engage with a more diverse group of stakeholders were highlighted in the Select Committee report:

*'Local authorities should use the limited central prescription on their Health and Wellbeing Board membership in combination with their influence across the local community, to work with a range people and bodies most closely linked to their areas' health needs and objectives.'*

**Select Committee report summary**

However, the report was concerned that, despite this, the reforms specifically excluded Councillors from attending CCG meetings. In their report, the Select Committee recommend that Councillors “are not specifically excluded” in this way. In the Government’s response to the report they state that; “Councillors are able to influence decisions affecting the health service locally through membership of health and wellbeing boards” (DoH 2013, p12), but states that it will “listen to representations on the effects of these regulations in practice” (DoH, 2013, p12).

There was also concern expressed that the initial use of ring-fenced budgets for public health could inhibit the full integration of public health staff within the local authority. Ring-fenced budgets were generally welcomed by public health professionals as being necessary, at least initially, to protect vital services (for example sexual health and substance misuse services), while allowing time for public health staff to form the relationships within the local authorities to justify their importance and secure ongoing funding. By contrast, local authority representatives felt that ring-fenced budgets were contrary to the spirit of localism and represented a barrier which was likely to prevent other local authority departments from fully engaging with the public health team.

The Select Committee report recommended that ring-fencing was justified, at least in the short-term:

*‘While the Department for Communities and Local Government recognises that local government does not like ring-fenced grants, we accept that, at least in the short term, some ring-fencing may be needed. But this should not become a permanent feature of the public health funding system in England.’*

#### **Select Committee report summary**

In addition, true integration may be limited by the amount of power and resources invested in HWBs. There are concerns that they may, at least initially, lack the capacity to influence and exert pressure upon the numerous relevant external stakeholders in health and social care. It was also felt that the relationship between CCGs and HWBs, whereby CCG representatives can sit on HWBs but not vice versa, was unbalanced, did not foster true integration and even had the potential to generate conflicts of interest in relation to the monitoring of CCG activities.

### 3. Autonomy versus Accountability

There was significant debate about the level of authority and degree of autonomy which public health professionals, specifically DsPH, should be accorded in the new system. While public health staff felt that they should be directly answerable to the Chief Executive of the local authority, even at the time of the Select Committee report there were examples given of the DPH having a third-tier status, reporting, for example, to the Director of Adult Social Care. The BMA, the trade union for Doctors, stressed the risks of losing skilled senior public health staff if their status and contractual arrangements were not preserved and comparable to NHS equivalents.

The Select Committee report stated that the DPH should “report directly to the Chief Executive of the local authority” and asked the Government to “reassert its understanding of this point, too”. The Government’s response was more equivocal:

*‘The internal management structure of local authorities is a matter for local authorities themselves. In its guidance on the role and responsibilities of the director of public health (DPH) the Department of Health made clear its view that there needs to be a direct line of accountability between the DPH and their chief executive (or other head of paid services) for the exercise of the authority’s public health function. This may or may not mean that the DPH should be a standing member of their authority’s most senior corporate management team’*

#### **Government response to report (DOH, 2013)**

Closely linked to the concept of autonomy was that of accountability. It was felt by public health professionals that the DPH should be sufficiently senior that they would have the autonomy to hold other areas of the local authority to account if necessary. Maintaining their independence was therefore seen as critical to being able to influence and enact real change. There was, however, some unease expressed by local authority representatives about the impact of such unfettered autonomy on the political priorities and agenda of the Council with its democratic mandate. This issue was not addressed in the report of the Select Committee.

#### **Opportunities and enablers**

Despite these challenges, all contributors broadly welcomed the key principle of the reform – relocating public health staff from PCTs to local authorities. Many of the challenges outlined relate primarily to the transition phase. These challenges form the context in which these public health reforms will be delivered. For each challenge there is a clear fault-line which typically divides clinicians and public health staff from local authority and Government representatives. Ensuring that potential fissures do not disrupt the process of

implementation depends on the harnessing of important enabling factors which can be summarised as:

1. Ensuring a shared focus on addressing social determinants of health
2. Intentionally investing in relationships between stakeholders
3. Focussing on detailed transition arrangements for public health and local authority staff

1. Ensure a shared focus on addressing social determinants of health

There was consensus that the social determinants of health, fundamental to any public health strategy, could be better addressed within local authorities than PCTs. Local authority representatives expressed an understanding of the social challenges facing their communities and felt that much of the work they were already tasked to deliver (for example in areas such as housing and planning) could be conceptualised as ‘public health’. The possibility of co-ordinating such strategies, while harnessing specialised public health expertise, was felt to offer significant opportunities to improve health at a population level.

Public health professionals were generally enthusiastic about the opportunities which this move presented. Again, this was primarily due to the greater opportunities to address social determinants in a way which was not possible when based within the NHS. Harnessing this shared enthusiasm with its potential to address social causes of ill health represented a major opportunity from these reforms.

The Select Committee report stressed the importance that local authorities take a holistic approach to addressing social determinants of health as part of their new responsibilities:

*‘Councils will need to focus all their policies and services on the social determinants of health—the social, economic and environmental reasons why people experience ill health or develop unhealthy behaviour—if they are to make an identifiable difference to the health and wellbeing of their residents.’*

**Select Committee report summary**

2. Intentionally invest in relationships between stakeholders

Some of the perceived insecurity which health professionals expressed regarding the reforms related to uncertainty about their status within local authorities, and how they would adjust to operating in a non-clinical environment. There was also concern expressed by local authority staff, that the reforms seemed too ‘NHS-led’ and that aspects ran contrary



to a localism agenda and respect for the expertise of local authorities. Such uncertainties could provoke conflict around issues of power, accountability and autonomy.

However, contributors with previous experience of partnership working between public health and local authorities broadly welcomed the transition. Close parallels between the workloads of GPs and Councillors were highlighted as an example of where seemingly disparate stakeholders actually shared considerable common ground. Developing relationships between such groups should be prioritised to enable the effective functioning of structures such as the HWBs. Furthermore, HWBs should be invested with sufficient power and resources to enable effective collaboration with the broad range of stakeholders they are expected to engage with.

### 3. Focus on detailed transition arrangements for public health and local authority staff

There was recognition from all contributors that the working environment within local authorities differs markedly from that of PCTs and the NHS more widely. Many public health staff will 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. Making this transition will present challenges to some public health staff and a process of formal training was recommended.

Similarly, further training for local authority staff will also be required to enable them to grasp the concept of public health and its broader social determinants. By highlighting the relevance of many pre-existing local authority functions to a public health agenda this should help encourage partnership working, foster collaborative relationships and enable transition arrangements. The importance of formal training in this area was highlighted in the Select Committee report:

*‘Local authorities, the Local Government Association, the District Councils’ Network and Public Health England should develop the skills required to communicate public health issues and ensure locally elected representatives, Board members and public health staff have access to such training’*

#### **Select Committee report summary**

Finally the issues of terms and conditions were raised as a potential barrier to the transition of public health staff, particularly those in senior positions. Considerable uncertainty was acknowledged about whether local authorities would be able to provide contracts equivalent to the previous NHS contract received by public health staff. Addressing such issues was felt to be critical to securing an effective transition of the workforce. These issues were not addressed in the Select Committee report nor in the Government response to it.

## **Concluding remarks**

The Committee's in-depth inquiry into the role of local authorities in health issues provided a wealth of data from which we have identified experts' key concerns and perceived opportunities of the reforms, in terms of their impact on the public health system. Our detailed analysis of the Select Committee report and evidence is a valuable adjunct to the national surveys and case study research being conducted by the PHOENIX team. It has highlighted some of the key anticipated concerns regarding the ways in which the recent structural reforms might affect the public health system. In particular, its governance, the relationships across the system, and in terms of public health activity. Our PHOENIX case study work is gathering further, richer data on these issues; examining the extent to which the anticipated opportunities and challenges of transitioning to the new system are being realised and concerns addressed, whilst also exploring how some of the contentious issues identified in this report are playing out in practice at a local level.

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## APPENDIX 1: LIST OF ORAL WITNESSES

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### Monday 19 November 2012

**David Buck**, Senior Fellow, Public Health and Inequalities, The King's Fund

**Graham Jukes**, Chief Executive, The Chartered Institute of Environmental Health,

**Dr Nicholas Hicks**, Milton Keynes Director of Public Health and Programme Director for Public Health to the NHS Commissioning Board,

**Dr John Middleton**, Vice-President, UK Faculty of Public Health and Director of Public Health, Sandwell PCT

**Duncan Selbie**, Chief Executive designate, Public Health England

### Monday 26 November 2012

**Cllr Steve Bedser**, Chair, Community Wellbeing Board, Local Government Association

**Cllr Alan Connett**, Executive Lead for Health and Wellbeing, District Councils Network

**Professor Gabriel Scally**, Director of WHO Collaborating Centre for Healthy Urban Environments, University of the West of England

**Dr Penelope Toff**, co-Chair, Public Health Medicine Committee, British Medical Association

**Dr Peter Carter**, Chief Executive, Royal College of Nursing

**Caroline Abrahams**, Director of External Affairs, Age UK

**Richard Blyth**, Head of Policy and Practice, Royal Town Planning Institute

**Andy Murdock**, External Relations and Policy Director, Celesio UK

**Paul Woodward**, Chief Executive, Sue Ryder Care

### Monday 3 December 2012

**Cllr Anthony Devenish**, Cabinet Member for Public Health and Premises, Westminster City Council

**Cllr Nick Forbes**, Leader, Newcastle-upon-Tyne City Council

**Liam Hughes**, Independent Chair, Oldham shadow Health and Wellbeing Board

**Cllr Mary Lea**, Cabinet Member for Health, Care and Independent Living, Sheffield City Council

**Kim Carey**, Corporate Director of Adult Social Services, Cornwall Council,

**Cllr Roger Gough**, Cabinet Member for Business Strategy, Performance and Health Reform, Kent County Council

**Dr Mike Grady**, Principal Adviser, University College London Institute of Health Equity

**Cllr Ernie White**, Cabinet Lead Member for Health, Leicestershire County Council

Monday 7 January 2013

**Professor Chris Bentley**, Independent Population Health Consultant

Monday 21 January 2013

**Anna Soubry MP**, Parliamentary Under Secretary of State

**Tim Baxter**, Deputy Director, Public Health Development Unit, Department of Health

**Baroness Hanham CBE**, Parliamentary Under Secretary of State, Department for Communities and Local Government

## APPENDIX 2: LIST OF WRITTEN SUBMISSIONS

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- Age UK
- Professor Chris Bentley, Independent Population Health Consultant
- British Medical Association
- Celesio UK
- Chartered Institute of Environmental Health
- Cornwall Council
- Department of Health and Department for Communities and Local Government
- District Councils Network
- Dr Mike Grady, Principal Adviser, University College London Institute of Health Equity
- Liam Hughes, Independent Chair, Oldham shadow Health and Wellbeing Board
- Kent County Council
- The King's Fund
- Leicestershire County Council
- Local Government Association and Association of Directors of Adult Social Care
- Newcastle-upon-Tyne Council
- Royal College of Nursing
- Royal Town Planning Institute
- Professor Gabriel Scally, Director of WHO Collaborating Centre for Healthy Urban Environments, University of the West of England
- Sheffield City Council
- Sue Ryder Care
- UK Faculty of Public Health
- Westminster City Council

## APPENDIX 3: CODING FRAMEWORK

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### CROSS-CUTTING THEMES

- Opportunities
- Threats

### MACRO CONTEXT

- Localism
- Health and Social Care Act
- Central Government
- Definition of public health
- Social determinants of health

### LEADERSHIP AND GOVERNANCE

- Leadership
- Monitoring
- Accountability
- Power

### STRUCTURAL CAPACITY

- Information resources
  - Information gathering
  - Data sharing
    - e.g. between local authorities and health organisations
  - Relationships
    - Within organisations
    - Between public health organisations
    - Public engagement
    - Government engagement
- Organisational resources
  - Integration
  - Collaboration
  - Old structures
    - Health Protection Agency (HPA)
    - Strategic Health Authority (SHA)
    - Local Involvement Networks (LINKs)
    - Primary Care Trust (PCT)
  - Current structures
    - Health and Wellbeing Boards (HWB)
    - Local Healthwatch
    - Healthwatch England
    - Clinical Commissioning Group (CCG)
    - District Councils
    - Public Health England (PHE)



- NHS Commissioning Board (NHS CB)
  - Local Authorities (LA)
  - NICE
  - Social care
  - Secondary care
- Human resources
  - Training
  - Contractual issues (e.g. terms and conditions)
  - Staff transfer
  - Staffing levels
  - Specific actors (including opportunities / concerns):
    - Directors of Public Health
    - Councillors
    - CCG members
- Fiscal resources
  - Funding streams
  - 'Ring-fencing'
  - Allocation of funding (e.g. standardised mortality rates)

### **PUBLIC HEALTH PRACTICE**

- Functions
  - Health promotion
  - Health protection / emergencies
  - Screening / early years
  - Immunisation
  - Drug misuse
  - Sexual health services
- Commissioning
- Community participation
- Transition
- Implementation
- Processes
  - Joint Strategic Needs Assessment (JSNA)
  - Joint Health and Wellbeing Strategy (JHSW)

### **OUTCOMES**

- Health
- Wellbeing
- Measuring outcomes
- Inequality
- Efficiency