

Integration, influence and change in public health: findings from a survey of Directors of Public Health in England

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ABSTRACT

Background Following the Health and Social Care Act in England, public health teams were formally transferred from the NHS to local authorities in April 2013.

Methods Online survey of Directors of Public Health (DsPH) in local authorities in England ($n = 152$) to investigate their experience within local government 1 year on. Tests of association were used to explore relationships between the perceived integration and influence of public health, and changes in how the public health budget was being spent.

Results The organization of and managerial arrangements for public health within councils varied. Most DsPH felt that good relationships had been established within the council, and the move had made them more able to influence priorities for health improvement, even though most felt their influence was limited. Changes in commissioning using the public health budget were already widespread and included the de-commissioning of services.

Conclusions There was a widespread feeling amongst DsPH that they had greater influence since the reforms, and that this went across the local authority and beyond. Public health's influence was most apparent when the transfer of staff to local government had gone well, when collaborative working relationships had developed, and when local partnership groups were seen as being effective.

Keywords organizations, public health, relationships

Background

Significant changes were made to the English public health system as part of the Health and Social Care Act 2012: a new national public health service (Public Health England) was created, health improvement responsibilities were transferred from Primary Care Trusts to local authorities, and a renewed emphasis was placed on the full role of NHS providers in tackling inequalities and ensuring every clinical contact counts. There is now a more complex commissioning and service delivery environment, with responsibilities split between a number of organizations.^{1,2} The move to embed public health within local authorities was broadly welcomed,³ and justified for a variety of reasons, including the ability to shape services to meet local needs, ability to influence the wider determinants of health and ability to tackle health inequalities, all of which are much wider than health service provision.

The reforms have also prompted concerns, however, about the potential loss of status and influence of Directors of Public Health (DsPH), about the impact on the public health workforce—particularly in terms of independence and fragmentation—and the future of core public health functions and services within cash-strapped local government.^{4,5} Other research has identified the leadership skills that public health

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practitioners will need, such as making effective relationships and powerful roles within the policy/decision-making process.^{6,7} Research by Willmott *et al.* found public health leaders to be aware of the need to achieve a balance between following traditional public health approaches and meeting the requirements of local politics and democratic accountability.⁸ Furthermore, a study by Yost *et al.* noted the range of tools to support evidence-informed public health decision-making.⁹

Previous empirical work, similar to this study, has highlighted the huge challenges of structural reform, the different cultural contexts public health has encountered in local government, and the variety of structural models that have evolved.^{10–17} The potential opportunities for a broader engagement in public health outcomes—through Health and Wellbeing Boards (HWBs) and across local authority directorates—have been acknowledged.^{4,18} The ability of public health leaders to influence others in the new system, and the consequent changes in the public health function, is beginning to emerge.

This paper reports on the findings of a national survey of DsPH undertaken as part of a larger Department of Health funded project examining the impact of structural changes in 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. The study involved a scoping phase, two surveys of DsPH and councillors with a lead responsibility for public health, and case studies in five areas of England. The case studies are closely examining the structures, processes and effectiveness of integrating public health functions in local authorities.¹⁹ Findings presented here focus on public health identity, leadership and the influence that public health leaders feel they have, and also on changes in commissioning for health improvement since the reforms.

Methods

An online survey (Supplementary data) was developed to explore the experience of public health teams within local government. The survey's content and design were informed by pre-existing research and consultation with external experts, including the Association of Directors of Public Health (ADPH). After pilot-testing and obtaining ethical approval, the survey was sent out electronically, during July 2014, under personalized emails to DsPH in all unitary and upper-tier county councils in England ($n = 152$), followed by up to two reminders. DsPH with responsibility for more than one authority were sent emails to answer for each authority separately, and asked to supply an alternative contact if they wished to delegate the responsibility. We sought, therefore, to obtain responses from as many of the 152 councils as possible.

Public health leaders' perceptions of their influence within local authorities and changes in commissioning from the public health budget are the focus of this paper (see **Box 1**). Statistical tests of association were carried out between aspects of influence and change compared with other factors, such as descriptors of the local authority and the way public health teams were organized and functioning following their move to local government.

Box 1

Survey questions on the influence of public health:

To what extent do you feel able to influence the priorities of your local authority? (Q21)

Since the reforms do you feel more/similar/less able to deliver real improvements in local health by: influencing the work of the local authority as a whole, influencing the work of the local CCGs, influencing the work of others, e.g. local workplaces, schools? (Q22 i, ii, iii, iv)

Apart from the ring-fenced budget, do you have influence over other departments' expenditure? (Q31)

Does your role on the HWB allow you to influence decision-making in your own organization, influence decision-making in other organizations locally and strategically influence work in the local health/social care economy? (Q38 i, ii, iii)

Survey questions about changes being made:

Since the April 2013 reforms, have you made any changes to services commissioned under the ring-fenced public health budget? (Q42)

Since April 2013, has your authority set up new services, changed the provider, re-designed services and de-commissioned services directed at health improvement? (Q43 i, ii, iii, iv).

Results

The survey achieved a response from 96 (63%) of the 152 local authorities, 79 (82%) of these were from unitary or single tier authorities and 17 (18%) from county councils. Survey replies were completed to a high standard overall, but some did not complete the survey fully and non-response to the questions used in this analysis was around 10–15% (see response rates in Table 1). Eighty-five per cent of respondents were DsPH, 7.5% were acting or interim directors and 7.5% had other job titles ($n = 93$). After the April 2013 reforms, 28% of the survey respondents were in a directorate of public health ($n = 90$) and 42% were managerially responsible to the Chief Executive ($n = 91$). Many reported that public health staff had built good relationships within the authority (79% saying 'definitely' and 19% 'to some extent', $n = 86$), although

Table 1 Tests of association between DsPH' perceived ability to influence local authority priorities (Q21, 90% response rate) and other variables

Variable type	Variable name	Response rate (%)	Chi-square	Degrees of freedom	P-Value
1. Influence	Since the reforms more able to deliver improvements by influencing the work of the local authority Q22ii	88	48.28	2	0.000
	Since the reforms more able to deliver improvements by influencing the work of the CCGs Q22iii	88	1.80	2	0.407
	Since the reforms more able to deliver improvements by influencing the work of others Q22iv	86	6.00	2	0.050
	DPH has influence over other department's expenditure Q31	90	15.67	4	0.003
	Being on the HWB allowed DPH—to influence decision-making in the authority Q38i	^a	5.89	2	0.053
	Being on the HWB allowed DPH—to influence decision-making in organizations locally Q38ii	^a	4.37	2	0.112
	Being on the HWB allowed DPH—to influence work in the local health/social care economy Q38iii	^a	2.17	2	0.337
2. Description of authority	Region (10 former England regions) ^b	98	19.30	18	0.374
	Type of authority (two-tier, unitary)	98	0.146	2	0.929
	Political party in power (Conservative, Labour, Liberal, no overall control)	98	4.37	4	0.358
	Population of authority (five categories) ^b	98	6.621	8	0.578
	Deprivation level (IMD 2010 score <26, 26+)	95	6.13	2	0.047
	Public health budget per head (<£50, £50–99, £100+)	98	4.22	4	0.377
3. Description of PH function	PH service shared across authorities Q1	100	1.47	2	0.480
	Grade/experience of PH leader (from Q6i and Q7)	97%	1.17	2	0.556
	Location of PH team (distinct team, or part of other directorate, or other arrangement) Q9 ^b	94	5.83	4	0.213
	Managerial responsibility for PH leader Q11	95	11.02	4	0.026
	PH team—good relationships (yes definitely, or not really/to some extent) Q17i	90	21.78	2	0.000
	PH team—valued Q17ii	88	6.27	2	0.043
	PH team – others know what they offer Q17iii	89	5.44	2	0.066
	PH team—asked for advice Q17iv	90	9.87	2	0.007
	PH team—advice trusted Q17v	83	10.28	2	0.006
	Requirement for other departments to collaborate with PH Q23	89	9.82	4	0.044
	Who authorizes expenditure (DPH alone, or DPH with others, or others (excluding DPH)) Q27	89	6.12	4	0.190
	PH business plan approved Q28	89	11.05	2	0.004
	DPH is on the health and wellbeing board Q36 ^b	89	7.76	2	0.021
	HWB—facilitating greater use of collective budgets Q37ii	84	2.21	4	0.697
	HWB—instrumental in identifying main health and wellbeing priorities Q37iv	48	23.68	4	0.000
HWB—making difficult decisions Q37vii ^b	48	4.53	4	0.339	
PH team has capacity to provide specialist support to CCGs Q41ii	84	5.51	4	0.239	
4. Change	Changes made to commissioning Q42 ^b	87	6.30	2	0.043
	New service Q43i	83	10.80	2	0.005
	Changed provider Q43ii	85	10.21	2	0.006
	Re-designed Q43iii	85	2.61	2	0.270
	De-commissioned Q43iv	83	1.49	2	0.474

^aResponse rate not known for tick box questions.^bTest not used due to small numbers.

fewer thought public health staff were highly valued (42% saying 'definitely' and 49% 'to some extent', $n = 84$). More details can be found in the full-survey report.²⁰

Influence of public health leaders after the 2013 reforms

This section looks at the survey questions about the perceived influence of public health following the reforms (see Box 1). The opening question about the director of public health's ability to have influence in their local authority showed that most respondents (66%) felt 'quite often able' to influence priorities in their authority, with the rest fairly equally split between 'always able' (15%) and not often or never able (19%) to influence priorities (Q21, $n = 86$, Fig. 1).

In related questions, asking how the influence of DsPH had changed following the reforms and how far their influence extended across the authority and beyond, many felt more able to influence the work of the local authority as a whole (82%, Q22ii, $n = 84$). Almost half (46%, Q22iv, $n = 83$) felt more able to influence the work of others such as local workplaces or schools. Across the local authority, a small proportion (10%) of respondents felt they had quite a lot of influence over other departments' expenditure; over half said they had limited influence (54% said 'yes, but not a lot'); and just over a third (36%) said they had no influence (Fig. 2).

Some of the questions about influence were specifically for members of HWBs (97% of respondents, $n = 85$). Those who sat on the HWB were positive about the influence they

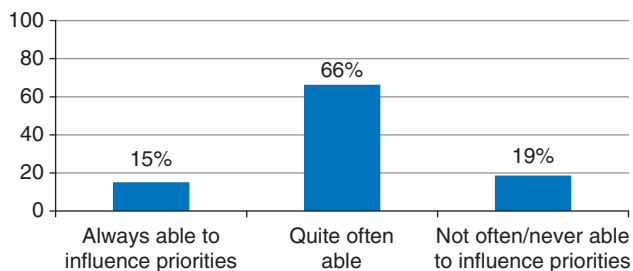


Fig. 1 Public health's ability to influence priorities in their local authority (% of 86 survey replies to Q21).

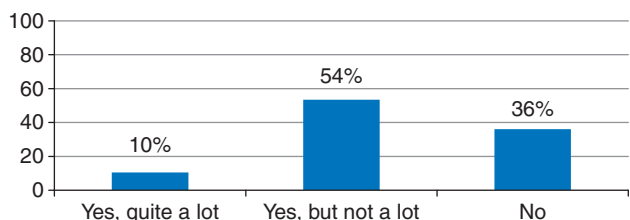


Fig. 2 Public health's influence over other departments' budgets (% of 86 survey replies to Q31).

felt this gave (Q38, $n = 82$), enabling them to influence decision-making in their own organization (64%), in other organizations locally (66%) and across the local health/social care economy (74%).

There were statistically significant associations between the responses to some of the questions about influence (first section of Table 1). DsPH who, since the reforms, 'always' felt able to influence priorities within their authority (Q21) also felt: more able to influence the work of the local authority (Q22ii, chi-square = 48.3, $df = 2$, $P = 0.000$); and that they had influence over other departments' expenditure (Q31, chi-square = 15.7, $df = 4$, $P = 0.003$). There was also an association between influence in the authority (Q21) and feeling able to deliver real health improvements in other areas like workplaces and schools (Q22iv, chi-square = 6.0, $df = 2$, $P = 0.050$).

Influence of public health compared with local authority characteristics

This section examines whether the views on influence varied according to characteristics of the authority where DsPH were based, such as the type of authority, the political party in power, the number of residents and the size of the public health budget. There were slightly more statistically significant associations at the 95% confidence level than would be expected by chance (tests of association were carried out between all the influence questions and local authority factors, although test results only for the opening influence question are given in part 2 of Table 1). Some of the local factors were associated with DsPH feeling able to influence priorities within the local authority (Q21), and having influence more widely in the local economy through their membership of the HWB (Q38ii, Q38iii). Specifically, while 15% of DsPH felt that they were always able to influence the priorities in their authority, this fell to 4% in areas with greatest material deprivation. Although DsPH had been positive about membership of the HWB, with 64–74% saying it enabled them to be influential in decision-making in various ways, there were situations where membership of the HWB was less highly valued. For example, in London boroughs (17 responses) compared with other types of councils, 59% of DsPH said that being on the HWB allowed them to strategically influence work in the local health/social economy compared with the average of 74% (chi-square = 8.9, $df = 3$, $P = 0.030$). In Conservative-led councils (25 responses), a lower percentage of DsPH said that being on the HWB allowed them to influence decision-making in other organizations locally (48% compared with the average of 66%, chi-square = 7.2, $df = 2$, $P = 0.027$).

The experience in two-tier authorities was compared with that in unitary authorities. There were some indications of

variation; 88% of respondents in two-tier authorities compared with 57% of those in unitary authorities said they had influence over other departments' expenditure, and they felt more able to influence the wider economy and had made commissioning changes, but the number of two-tier authorities in the survey was small ($n = 17$), and none of these differences were statistically significantly different from the experience in unitary authorities.

Influence of public health compared with the team's organization and functioning (post reforms)

We looked for other factors associated with influence, such as how the public health team was organized and operated within the local authority and how the HWB was functioning. The statistical tests of association carried out with these variables and all the questions about DsPH' influence found considerably more significant associations than would be expected due to chance (results are given for the opening influence question in part 3 of Table 1). The strongest statistical association with influence was found when public health teams had built good relationships within their authority. DsPH who were managed by the council's Chief Executive were also more likely to say that they were always able to influence priorities within the local authority (23% compared with the average of 15%). Similarly, where respondents felt they had little influence, they also felt that the public health team was not really being valued, not being asked for advice, or the information they supplied was not really being trusted. Respondents' abilities to influence local authority's priorities were also associated with a requirement by other departments to collaborate with public health on their plans, with HWBs being clearly instrumental in identifying health priorities, and

the council's cabinet engaging in the process of approving public health business plans. See Table 1 for figures.

Changes made to commissioning for health improvement

The survey asked about changes in commissioning for health improvement following the reforms (see Box 1 and results of change compared with the opening question about influence in final part of Table 1). Since the reforms, almost all DsPH (94%, $n = 83$) reported having made changes to services commissioned under the ring-fenced budget (Fig. 3), which included setting up new services, changing providers, re-designing existing services and de-commissioning services. In addition, 94% (Q43v, $n = 81$) said they had started the process of re-tendering health improvement services.

Changes in commissioning were more common in authorities where the DsPH felt that they were 'always' or 'quite often' able to influence the priorities of their authority, compared with those 'not often' or 'never' able. For example, these authorities were twice as likely to have set up new services (77% compared with 38%, $P = 0.005$) or to have changed the provider of an existing service (76% compared with 38%, $P = 0.006$).

There was a statistically significant association indicating that there were more reports (76% compared with 56%, chi-square = 5.7, $df = 1$, $P = 0.017$) of de-commissioning services in areas with greatest material deprivation. However, this was the only association found between local authority characteristics and changes in commissioning and could be due to chance.

Some changes were happening more often with particular organizational circumstances, but similar to the comparisons

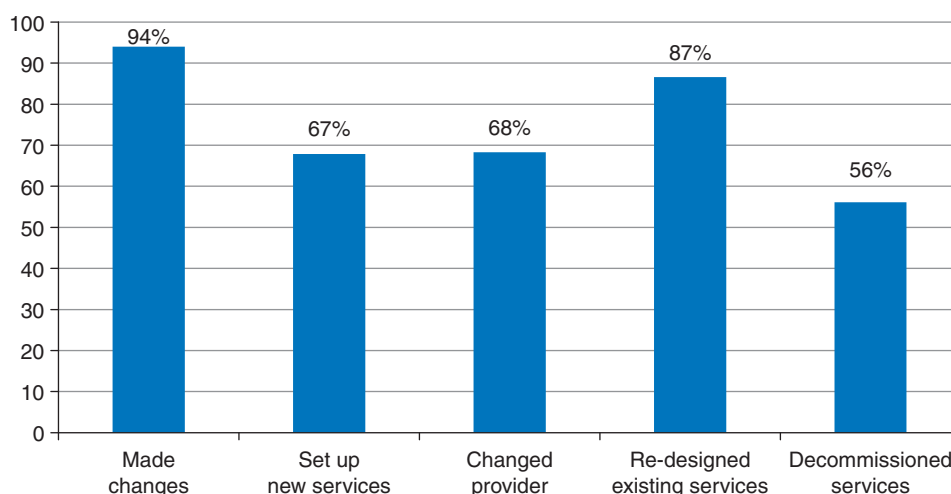


Fig. 3 Changes made to commissioning services under the ring-fenced public health budget (% of 81–83 survey replies to Q42, Q43i, ii, iii, iv).

with local authority characteristics, the number that was significant is what would be expected due to chance. Where there was a requirement for other departments to collaborate with public health on their plans, it was more likely for new services to be set up (84% compared with 68%, chi-square = 11.8, $df = 2$, $P = 0.003$). Also, where the HWB was 'definitely' instrumental in identifying health priorities, it was more likely that new services had been set up (85% compared with 68%, chi-square = 13.6, $df = 2$, $P = 0.001$), and that providers of existing services had been changed (79% compared with 68%, chi-square = 6.8, $df = 2$, $P = 0.033$). Service re-design and starting the re-tendering process were both more common for DsPH with more years' experience in their post or in their authority, suggesting stability of leadership within public health is an important factor (statistical tests not used due to small numbers).

Discussion

This survey provides useful insights on the views of DsPH and how their roles are developing since they move to local government. Two limitations of this study design are the sample, which was constricted to DsPH only, and the data collected, which was perceived influence only. We can therefore only present reflections on how influential DSPH think they are, rather than on their influence as evidenced objectively. The Government's key aims for integrating public health into local government were to provide opportunities for working across authorities (e.g. with education, social care, planning, transportation) and to provide local democratic leadership to build '... a new, enhanced locally-led 21st century public health service, where innovation is fostered and promoted ...'.²¹ The data from our survey suggest that, while not yet substantial in scale, the relocation of public health is achieving some of the outcomes and the direction of travel envisaged by policy makers. This finding is reflected in our deeper case study research, where we found that new managerial structures and accountability were providing opportunities for public health to think differently and take fresh approaches.¹⁹

The results highlight that, following structural reforms, public health had been set up and organized within local government in a variety of ways and with different managerial arrangements. Before 2013, fears had been expressed that with the move to local authorities the role of the DPH would be marginalized.¹⁸ The survey results indicate that DsPH do not feel marginalized, with most having already established good relationships within their authority and feeling valued in their new institution. However, while the move has made DsPH more able to influence priorities for health and health

improvement, such influence was often limited. Akin to this, similar research into the challenges faced by leaders in the NHS²² highlights that challenges are almost insurmountable, due to the 'disconnects' caused by differences in structures, values and purpose, and that a sense of being able to be influential can be a delusion. Working within local authorities has provided opportunities for DsPH to influence other areas of local authority activity (such as workplaces and schools), but significantly, given their statutory role, little influence over Clinical Commissioning Groups (CCGs).

DsPH seemed more likely to feel well-embedded and working effectively following the 2013 reforms when they reported directly to the Chief Executive, when collaboration with other departments was required, and where there was more engagement in approving public health plans. Public health teams saw themselves as being less effective in authorities where the transfer of public health had not gone so well in terms of establishing good relationships and trust. Some factors were less easy to interpret and may simply reflect the differing types of authorities—for example, the perception of public health teams in upper-tier county authorities that they had greater influence over priority-setting, and those in areas with higher levels of material deprivation feeling they had less influence.

Although this study did not ascertain the nature or extent of changes in commissioning, it showed that nearly all authorities had made changes to services purchased under the public health ring-fenced budget by August 2014. Changes, such as setting up new services or changing service providers, were more likely in authorities where public health leaders felt that they were influential. Comparing our findings with previous surveys,^{11,16} we can see that changes in commissioning accelerated rapidly towards the end of the first year of re-organizing public health.

A survey in October 2013 undertaken by the ADPH of their membership found a similarly wide variety of structural and managerial arrangements, with DsPH reporting they had good access to councillors and appropriate influence across their authority.¹⁰ The ADPH also noted that in a fifth of authorities, there was no substantive DPH in post, and that acting or interim DsPH had much less influence in how the ring-fenced public health budget was being spent.

Other research has noted the different culture in which public health teams find themselves, that decisions are often based on political pressure rather than evidence, and that in the new environment they would benefit from having better influencing skills.¹⁷ While broadly in line with previous research,^{5,6,11,12} our findings give a fuller picture of public health following the April 2013 reforms as they are based on a wider range of questions and an examination of relationships between these.

In summary, the survey showed a widespread feeling among DsPH in local government that they had greater influence since the reforms, and that this went across the local authority and beyond. The influence of public health professionals was most apparent when the transfer of staff to local government had gone well, when collaborative working relationships had developed, and HWBs were seen as being effective locally. Changes in commissioning using the public health budget were already occurring and included in the de-commissioning of services. The findings are encouraging with respect to the extent to which the public health role has become more embedded within local authority organizational structures and integrated with other aspects of local authority work. However, DsPH still report having limited influence and, with many local authorities undertaking further internal restructuring with public health placed in larger directorates, the influence of public health may be diminished, for example, if direct managerial relationships with chief executives are lost. Our current study will augment these findings with the perspective of elected members²⁰ and with a follow-up survey to identify how the position, role and impact of public health in local government continue to change. Also within the wider research project, the in-depth case studies are shedding more light on how current organizational changes affect the new local government public health role. Results from early stages of the research are reported elsewhere¹⁹ and a full analysis and report will be published in early 2016.

Supplementary data

Supplementary data are available at *PUBMED* online.

Acknowledgements

We would like to thank DsPH and others who participated in the survey.

Funding

This work was supported by the Department of Health. The views expressed are those of the researchers and not necessarily those of the Department of Health.

Conflict of interest

None declared.

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