Exploring how Health and Wellbeing Boards are tackling health inequalities with particular reference to the role of environmental health

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**Abbreviations**

CIEH- Chartered Institute of Environmental Health

CCGs- Clinical Commissioning Groups

DPH- Director of Public Health

EBM- Evidence based medicine

EBP- Evidence based practice

EH- Environmental Health

EHC- Environmental Health Commission

EHO- Environmental Health Officer

EHP- Environmental Health Practitioner

FSA- Food Standards Agency

HWBs- Health and Wellbeing Boards

HSCA12- Health and Social Care Act 2012

JSNA- Joint Strategic Needs Assessment

JHWBS- Joint Health and Wellbeing Strategy

LINks- Local Involvement Networks

LA- Local Authority

LG- Local Government

MoH- Medical Officers of Health

NHS- National Health Service

NICE- National Institute for Health and Care Excellence

PCT- Primary Care Trust

PH- Public Health

PHE- Public Health England

WHO- World Health Organisation
Abstract

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Health and Wellbeing Boards (HWBs) are new local government (LG) sub-committees tasked with assessing local health and social care needs, and developing strategies for promoting integration and tackling health inequalities; yet they have no statutory authority to compel action. This research explored how they approached tackling health inequalities, focussing on the role of environmental health (EH), the LG public health occupation, in the pre-shadow and shadow stages and as they went live in April 2013.

Four case study sites (based around individual HWBs) were purposively sampled to ensure that a variety of HWBs were included, including unitary and two-tier authorities and urban, suburban and rural areas. Data collection at each case study site included semi-structured interviews, observation of HWB meetings, and documentary analysis and extended for 18 months from early 2012. In addition, EH practitioners and managers were interviewed from each of the English regions to provide a wider context. The data was analysed thematically both inductively and deductively using Atlas.ti. and conclusions drawn.

HWBs were varied in their structures, practices and intentions and some changed considerably during the research, as would be expected at a time of new policy development and implementation. There was evident commitment and enthusiasm from HWB members to improve the health of local populations. However it is unclear what ‘success’ will be or how it will be measured and attributed to the work of the HWB, and there were some tensions between the various parties involved. There was an espoused commitment to the principles of Marmot, in particular to children, however much of the focus during HWB meetings was on integrating health and social care. Taking action on many of the social determinants of health is outside the core sphere of HWB control, however they did not generally appear to be utilising some of the readily available tools, such as EH work to improve local living and working conditions. EH was found to be largely ‘invisible’ within its own public health community and does not have a tradition of evidence based practice needed to secure funding in the new system. This, along with the decline of the regulatory role, has led to a period of reflection and adaptation.

The research findings are linked by the policy approaches of ‘doodle’ and localism, including the shrinking of the state, and in particular the retreat of statutory and regulatory roles and the introduction of overt political values in policy making; shifting the focus to relationships, partnership-building, integration and the impact of individuals. The contexts in which the research has taken place, both at local and national levels, including financial austerity, major health restructuring, and high national and local expectations are all significant factors which have shaped the findings.
Declaration

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The author

I have embarked on this PhD as a mature student with a background in environmental health. The implications and effects of this on the research are discussed in detail in chapter 11 of this thesis.

I hold a BSc(hons) in Environmental Health from Kings College, University of London; a MSc in Public Health from Oxford Brookes University; and a NEBOSH Diploma in Occupational Health and Safety.

My research experience so far has been diverse within the field of public health. My dissertation for the BSc focussed on issues around the payment of housing benefit for very poor quality (at that time called ‘unfit’) residential premises. My dissertation for the MSc looked at whether national health and safety priorities were relevant to Birmingham City Council, and led to the development of a workplan based on local needs; and my project for the postgraduate diploma included the development of health and safety documentation and procedures for environmental health staff.

I am a founder member of the UK Environmental Health Research Network (EHRNet), with four other academics, which aims to develop research and publication in environmental health, and am also guest lecturer on ‘communicable disease and environmental health’ at Oxford Brookes University.

As a chartered environmental health practitioner, I currently work freelance around my studies and specialise in providing support for large event organisers and caterers. Prior to this I worked for 10 years in local government environmental health, most recently as Health and Safety Team Leader at Birmingham City Council, on secondment to the Health and Safety Executive as the Midlands Partnership Liaison Officer.

My motivation for including both health inequalities and environmental health as major themes in this research is summed up by my former lecturer from Kings College;

‘we should recognise where the gaps exist... and then do something ourselves to fill it... [because]as a group of front-line professionals we encounter in our daily round most, if not all, of the stressors that impact on human health, and driven by a desire to better the lot of those dealt a poor hand from the start, challenge the environmental service to deliver to the needs of those who may not have the capacity to speak up for themselves,’ (Day 2011 :64).
1 Introduction

Health and Wellbeing Boards (HWBs) are a significant element of the recently restructured English public health landscape. They were formally established in the Health and Social Care Act 2012, but do not have any statutory powers to compel action, nor do they hold budgets for commissioning. HWBs have been charged with setting the local strategic direction for health, including considering health inequalities as part of developing Joint Strategic Needs Assessments (JSNAs) for their local areas. However, much of the narrative, legislative and policy emphasis has been on integrating health and social care. HWBs are essentially new local government (LG) committees, but are particularly novel in that they mandate the bringing together of GP commissioning groups, elected members, council officers and others on an equal footing, and in all areas.

Health inequalities are complex and intractable, and are also known as ‘wicked’ issues (Hunter, Marks et al. 2010). The term describes the well-documented differences in health (both morbidity and mortality) between people in different socio-economic groups; with better health experienced by people in higher socio-economic positions (Marmot and Wilkinson 2006). Health inequalities represent a great deal of avoidable suffering (Marmot 2010). There are many models and suggestions as to why they exist and what should be done to address them (Bartley 2004), and the factors which have been identified as the ‘social determinants of health’ (Marmot and Wilkinson 2006). Addressing these factors has been described as an important objective across the lifecourse in the ‘Marmot Review’ (Marmot, 2010).

Environmental Health (EH) is a public health occupation, with a regulatory role, based in LG. This regulatory role sets it apart from other PH occupations, as does its historic local authority home, following the health service and LG restructure in 1974, when other PH occupations shifted to the NHS. The function is primarily preventative and is focussed on improving living and working conditions for local populations. There is a strong link between the role of EH and the social determinants of health across the lifecourse as described by Marmot.

HWBs have certain statutory officer members, including Directors of Adults and Children’s Services, and the Director of Public Health; however EH does not have statutory membership. In the UK, local authorities (LA) are either single tier or two-tier. Essentially, single tier Authorities operate in metropolitan areas, and some rural county areas and carry full responsibility for all LA functions. In other areas, responsibilities are split between county-wide ‘upper tier’ authorities and
more local district or borough councils, also known as ‘lower-tier’ authorities, (although this term is somewhat misleading and unpopular). HWBs are also located in unitary and ‘upper tier’ local authorities (LAs), whereas in two-tier systems EH is located at the district or borough level, i.e. in some areas, HWBs and EH are in separate and autonomous organisations. District councils also do not have statutory membership of HWBs, although they must be consulted on the preparation of certain strategy documents. There is no limitation on the number of non-statutory members that HWBs may have.

The central aim of the research was to explore whether (and if so how) HWBs were beginning to tackle health inequalities, and within this, whether EH was seen as having a role. Addressing these aims required consideration of how HWBs and their associated organisations and occupational groups were developing and responding at local levels. Four case study HWBs were followed in the Midlands and North of England and data from EH practitioners and managers in each English region provided additional context. Qualitative methods were used, comprising semi-structured interviews, observations of HWB meetings, and analysis of documents such as minutes of meetings and strategies. Data collection took place during the ‘pre-shadow’, ‘shadow’ and ‘live’ stages of HWB development from December 2011 for 18 months.

Whilst there is some early literature on the development of HWBs, this has primarily been in the form of opinion pieces, focussing on integrated care, or necessarily covering only a short period of time. The approaches of HWBs to tackling health inequalities has similarly been lightly treated, and the role of EH as a PH occupation in LG has not been considered empirically in any depth for some 19 years and is a greatly under-researched area. This research is therefore both timely, and necessary in establishing the English policy position and its consequences ‘on the ground’ around these interweaving and overlapping themes.

Following this short introductory chapter, the thesis begins by providing a broad overview of the background literature, including the legislative and policy, and economic and political contexts. Health inequalities, including the social determinants of health, are discussed, as is EH as a PH occupation and the role of evidence based practice in the new English PH system. LG structures and partnerships and joint working with health services are explained, and finally, Harrison’s ‘Design to Doodle’ conceptual framework is introduced.

Chapter 3 sets out the research design and methods, including justification for the approaches taken and the impact of my background as an EH practitioner on the research.
The results representing the new contribution to knowledge provided by this research are set out in chapters 4-10. Chapter 4 describes local HWB structures, constitutional matters and agenda setting; including channels of communication between various individuals and organisations. The impacts of local politics, including electoral cycles are also discussed.

Chapter 5 sets out the tensions found in the new English PH system, including between local politicians, officers and health services representatives. Tensions between LG tiers are also discussed, including consideration of the impact of historic relationships, and the possible consequences of conflicts and tensions.

Chapter 6 looks at the interface between HWBs and GP clinical commissioning groups (CCGs), including consideration of representation and participation, structures, and the impact of CCG authorisation during the HWB ‘shadow stages’ of development.

Chapter 7 considers the similarities and differences in HWB espousing and enacting in relation to health inequalities, and in particular the impact of the Marmot Review in influencing policy and strategy. Differences in understanding of health inequalities and the role of EH are also discussed.

Chapter 8 looks at the role and impact of evidence based practice in the English PH system, and the impact of this on EH and other LA occupations which do not traditionally measure their outputs and outcomes in this way.

Chapter 9 describes the phenomenon of EH ‘double invisibility’ and considers the possible reasons for this and how it might be overcome; and Chapter 10 looks at how EH practitioners and managers have reflected on and adapted to the changes to the PH system. This includes consideration of the ‘burdens on business’ anti-regulation rhetoric and policies of austerity.

The results are discussed in Chapter 11, including returning to Harrisons ‘Design to Doodle’ spectrum and considering public management theory, and the impact of politics and localism on policymaking. Implications of the findings on policy and practice are also considered, as are future research questions building upon this work. There is a short section on reflexivity, and the strengths and weaknesses of the research are also set out. Finally, concluding remarks are made.
2 Literature review

This chapter provides an overview of the relevant literature, setting the context for the research, questions and study design, findings and discussion. I start by describing the legislative, policy, economic and political contexts in which the research was carried out. I then discuss health inequalities, environmental health as a public health profession, and evidence based policy and practice. Finally, local government (LG) structures in England, and previous initiatives to encourage partnership working between LG and health services are described.

2.1 Legislative and policy context
The concept of Health and Wellbeing Boards (HWBs) was initially publicly proposed in the ‘Healthy Lives, Healthy People: Our Strategy for Public Health’ White Paper (Department of Health 2010) and the Health White Paper ‘Equity and Excellence’ (Department of Health 2010) both published in July 2010. Moves were made to create and develop HWBs locally as the Health and Social Care Bill was published in 2011. However the passage of the bill was troubled (Timmins 2012) and the Health and Social Care Act (HSCA12) was not passed until March 2012, with the unusual situation of HWBs expected to be set up in shadow form the following month in April 2012.

In anticipation of the successful passing of the HSCA12, many events were held and documents published on the role and development of HWBs by a variety of different organisations throughout 2011 (BMA 2011, Local Government Association 2011, The Association of Directors of Children's Services 2011). However detailed guidance from central government was not so forthcoming and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 covered only limited and specific governance issues, such as the removal of political portionality rules. The guidance documents available during the shadow stage of HWB development were generally produced by the Local Government Association, The King’s Fund and the NHS Confederation and not central government, although the Department of Health did produce some specific statutory guidance on Joint Strategic Needs Assessments (JSNAs) and Joint

The most detailed and practical guide was produced by the Local Government Association and The Association of Democratic Services Officers in March 2013, again immediately before HWBs went live in April 2013 (Local Government Association and Association of Democratic Services Officers 2013). This guide confirmed the following:

‘The legislation was aimed at allowing considerable flexibility to councils and their partners on health and wellbeing boards to set up and run boards that conform to these principles in a way that suits local circumstances. This means that a range of options will be possible.’ (2013 :4)

Interestingly, a consequence of the significant guidance being produced by other organisations is that central government has seemingly had only limited involvement in the policy detail and implementation of HWBs has varied locally. It is worth considering that those developing the policy detail may or may not have similar aims and objectives to legislators. Harrison’s concept ‘From Design to Doodle’ describes the change in approach to health policy by successive governments, from the initial use of a detailed ‘blueprint’ in the LG reorganisation of 1974, to the introduction of a ‘bright idea’ for development and implementation by others, as we see today in the introduction of HWBs (Harrison 2011). This concept is discussed in greater detail and in the light of the findings of this research in chapter 11.

Although the passage of the HSCA12 was somewhat fraught, the idea and introduction of HWBs was generally welcomed and seen as the least controversial part of the recent changes to the health and PH systems in England, which is perhaps why they received little media attention (Wilderspin 2013). There were, however, some critics who dismissed claims that HWBs would improve the democratic legitimacy of the NHS (Fitzpatrick 2011) and others felt that they ‘will not be sufficient to ensure a partnership approach to improving health and wellbeing’ (Kingsnorth 2013 :73).

The purpose and role of HWBs is to create a forum of relevant professional groups, local elected members and others tasked with carrying out a joint strategic needs assessment
(JSNA) and developing a joint health and wellbeing strategy (JHWBS) for their areas with a ‘core purpose …to improve local health and social care and to reduce health inequalities’ (Local Government Improvement and Development 2011 :7). However there is no specific duty in the HSCA12 to tackle health inequalities. There are duties to establish HWBs and to encourage integrated working which are contained in Sections 194 and 195 of the HSCA12 respectively. More recently, their role has been described as ‘system leaders’, working beyond the strategic role described above (Wilderspin 2013).

The JSNA is intended to provide a detailed analysis of the health and social care needs (and some would include assets) of the population in a given geographical area. The preparation of JSNAs has been required of upper tier LAs and the NHS since 2007, so they are not new. However the responsibility of the multi-agency HWB to produce a strategy to meet the needs identified in the JSNA is novel (Local Government Improvement and Development 2011). It is the duty to produce a JHWBS required by Section 193 of the HSCA12 which includes the expectation that health inequalities will be addressed. The statutory guidance on JSNAs and JHWBS clarifies the situation with regard to health inequalities, emphasising the need for ‘evidence’;

‘The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning – the core aim is to develop local evidence based priorities for commissioning which will improve the public’s health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing’ (Department of Health 2013 :4)

A toolkit for JHWBS was published in September 2013, some 6 months after HWBs went live, which emphasises that they ‘are not one-off documents but are a live, continuous process of strategic assessment and planning...’ (NHS Confederation 2013 :1). There is a technical anomaly in that whilst the HWB must prepare the JSNA and JHWBS, it does not
have a duty to publish them, as this responsibility lies with CCGs and LAs (Department of Health 2012).

The Department of Health (DoH) describes HWBs functions as bringing

‘together those who buy services across the NHS, public health, social care and children’s services, elected representatives and representatives from HealthWatch to plan the right services for their area. They will look at all health and care needs together, rather than creating artificial divisions between services’. (Department of Health 2011)

There is thus a clear emphasis on joint working and integrated care.

Although health services, social care services and health-related services are defined and frequently mentioned in the HSCA12, there is no clear definition of ‘wellbeing’ in the legislation or guidance relating to HWBs and an historical perspective is useful here. The Local Government Act 2000, Section 2, provided for a LG power to do anything considered to promote or improve economic, social and environmental well-being. However no definition was included in the legislation (HM Government 2000) and it should be noted that this was a new power and not a duty. In 2009, guidance on the 2000 Act was published following an amendment in the Local Government and Public Involvement in Health Act 2007 relating to LA eligibility to use the wellbeing power. The guidance does not specifically provide a definition, however Section 58 is useful and indicates that the use of the power was expected to differ at local levels;

‘The Government considers the term “promotion of economic, social or environmental well-being” to be sufficiently broad to encompass both cultural well-being and the promotion or improvement of the health of a council’s residents or visitors to the council’s area. It is for an eligible council itself to decide whether any particular action taken pursuant to the well-being power would promote or improve well-being, taking account of the local circumstances and the wishes and needs of the communities it serves. To this extent, the nature and appropriateness
of the use of the well-being power will differ for each eligible council.’

(Department for Communities and Local Government 2009 :14)(my emphasis)

Walker helpfully adds that ‘health’ and ‘wellbeing’ have been used interchangelably, but that the term ‘health’ alone is restrictive as it ‘tends to have the traditional ‘disease focus’’ (Walker 2012 :17). He also argues that ‘to be useful in everyday life – rather than just in the annals of philosophers, psychologists and the like- wellbeing needs to be measurable’ (Walker 2012 :42). Recent guidance in a toolkit for drafting a JHWBS emphasises the need to include a focus beyond health to include wellbeing, and gives some useful examples including ‘rural isolation, loneliness, fuel poverty, social housing provision and misuse of alcohol and tobacco’ (NHS Confederation 2013 :8). There has been some work on the measurement of wellbeing, but this does not appear to be linked to HWBs in policy terms. The Office for National Statistics has recently developed a list of 41 measures of wellbeing and these have been categorised into ten domains; natural environment, personal wellbeing, our relationships, health, what we do, where we live, personal finance, economy, education and skills, and governance (Office for National Statistics 2013) and it appears that these strongly correlate with the social determinants of health described by Marmot and Wilkinson (2006) and later Marmot (2010) but do not fit neatly with the statutory role of HWBs as legislated in the HSCA12, which emphasises integrated health and social care.

The New Economics Foundation have also developed a model of wellbeing including how it could be measured, they describe wellbeing ‘as how people feel and how they function, both on a personal and social level, and how they evaluate their lives as a whole’ however they are clear that the concept does not directly equate with happiness, although they are linked (Mahoney and Michaelson 2012).

Returning to the more recent legislative changes, health-related services are defined in Section 195 of the HSCA12 as ‘services that may have an effect on the health of individuals but are not health services or social care services’ and this is relevant when considering the roles of environmental health (EH) and other LG professions in the new system. The same section of the Act gives HWBs the power (but not a duty) to ‘encourage persons who arrange for the provision of any health-related services in its area to work
closely with the Health and Wellbeing Board’. This wording clearly gives little leverage for health-related services to find a voice in the system where they are uninvited or overlooked.

During the HWB development stages there were 138 volunteer ‘early implementers’ (House of Commons Select Committee on Health. Communities and Local Government Committee 2013 :8) out of a possible 152 upper tier LAs who signed up to create ‘shadow’ HWBs and which were said to have formed an ‘early implementer network’ (Behan 2011 :2). There was also a network of ‘Core Cities’ of the eight largest (non-London) city councils, working on a ‘joint steer of HWBs’ (Kidd 2011), and a national online forum set up on which HWB members and support officers could raise issues and share information (Local Government Association 2013). The government made it clear that most upper-tier local authorities (LAs) should have ‘shadow’ HWBs in place by April 2012, becoming fully operational in April 2013 with an additional £1 million announced to support their development (Department of Health 2011). This steer resulted in three identifiable HWB stages; the ‘pre-shadow’ stage up until April 2012; the ‘shadow’ stage from April 2012-March 2013; and the ‘live’ stage from April 2013 onwards. This research covers periods of all three stages.

Upper-tier LAs are the authorities responsible for HWBs and there is no duty or requirement for district and borough councils to have a seat at the board, to be consulted or to be otherwise involved, (with the exception of the drafting of the JSNA as described below) (Chartered Institute of Environmental Health 2010), an omission for which the government was criticised by the Health Select Committee (Williams 2012), and seen in much previous policy historically. HWBs are required to involve both patients and the public in their work (Behan 2011) and this is generally in the form of a representative of Local Healthwatch (which are new organisations representing patients and the public). LAs are free to determine the number of elected members on the HWBs, though this has promoted concerns about the politicisation of decision-making and the need to ensure that the most suitable members are present (Calkin and Ford 2011).

Statutory members of HWBs include council officers (Directors of Adults and Children’s Services and Director of Public Health), an elected member (usually the Council leader or portfolio holder for health), Clinical Commissioning Group (CCG) representatives (which
are new organisations responsible for healthcare commissioning, excluding primary care, following the abolition of Primary Care Trusts), and a member of Local Heathwatch. A representative of NHS England (responsible for primary care commissioning, some specialised services and ensuring that CCGs are performing) must also attend when the JSNA, JHWBS and, if requested, when their commissioning functions are discussed. (Department of Health 2012).

Many HWBs have also included non-statutory members, for example additional elected members, representatives of district and borough councils in two-tier systems, the police, healthcare providers, the voluntary sector and other organisations. Non-statutory members have equal voting rights with statutory members and the number of HWB members in each area is variable, ranging from less than 12 to more than 20 (Humphries, Galea et al. 2012). There have been some concerns that the inclusion of providers could cause a conflict of interest, and this has been described as a ‘tension’ in the HWB role which requires managing (Humphries 2013 :8), although some consider the engagement of providers to be essential (Mumford 2013).

Very few HWBs have EH, the LG PH occupation, directly represented. In an early briefing (2011) to the Chartered Institute of Environmental Health (CIEH) Anne Milton, the then Public Health Minister made a speech about the proposals, which included the following comments on lower-tier involvement and an emphasis on local decision-making:

'And let me be clear: that absolutely includes district and borough councils. It’s something I know the Institute is particularly worried about – this fear that lower tier authorities will be forgotten or ignored. To be fair, it has happened in the past. County councils zooming off in one direction. Second tier authorities going the other way. Those days are over. Our reforms simply won’t work unless lower tier authorities and their workforce are in the loop. I’m not going to prescribe local structures, processes and membership. That, quite rightly, is best decided locally. But the Health and Wellbeing Boards and the Joint Strategic Needs Assessment should give all parts of the system a chance to get involved. No voice, no opinion,
no professional group should be excluded if those outcomes are to be met.’ (Milton 2011)

The statutory guidance on JSNAs and JHWBS states that in two-tier areas, district councils must be involved in the drafting of JSNAs, it also says that they should be involved in the drafting of JHWBS, although it acknowledges that this is not a requirement of the HSCA12. In addition, it states that HWBs should work closely with ‘other local partners’ giving a list of examples, including environmental health officers (Department of Health 2013 :12).

The figure below shows the relationship of statutory and possible non-statutory members with HWBs.

Figure 1 The statutory members (solid blue boxes) and possible non-statutory members or (blue outlined boxes) of organisations and individuals of a HWB in a two-tier system, as officially intended.
There was some expectation at the outset that most CCG and LA boundaries would be coterminous (Behan 2011) and that these would form the HWB areas (Staite and Miller 2011). However this arrangement has proved to be patchy and recent reports indicate that priorities of HWBs and CCGs for the same area often have little or nothing in common (West 2013). HWB views were taken into account during the approval of CCGs and they have the right to refer commissioning plans back to the groups or ultimately to NHS England (formerly called the NHS Commissioning Board), though they will not be able to block or veto them (Department of Health 2011). In practice, HWBs primarily rely on political and other leadership and influence (Humphries, Galea et al. 2012, Sillett 2012) and building strong relationships (House of Commons Select Committee on Health, Communities and Local Government Committee 2013, Humphries 2013) as they do not have any real powers to enforce change, cannot apply sanctions, and cannot veto commissioning plans (Calkin and Ford 2011); this has been described as a ‘soft’ role (Staite and Miller 2011 :9). An example of this HWB soft role is the ‘power to encourage close working (in relation to wider determinants of health)’ (Department of Health 2012 :3). It is difficult to envisage how this power ‘to encourage’ could effect real change in areas where parties are reluctant to co-operate or leadership is weak.

From the initial publication of the White Papers (Department of Health 2010, Department of Health 2010), the idea of HWBs developed and they were at one time anticipated to have a lead commissioning role (Behan 2011). However, at the time of writing it appears that HWBs will have no direct commissioning responsibilities, but instead are expected to influence the commissioning decisions of LAs and CCGs by providing local strategic oversight. As outlined above, HWBs are required to carry out a JSNA, followed by a JHWBS to meet the identified needs of the local population. CCGs and LAs are required to commission ‘in line with the health and wellbeing strategy’ (Behan 2011 :2, Pulse 2011) and this is expected to ‘encourage a shared understanding of local priorities’ (Behan 2011 :1).

The figure below shows the route of HWB influence on local commissioning decisions as originally intended (Dhesi forthcoming).
The route of HWB influence on commissioning decisions as originally intended

The promotion of joint working between occupational groups in health and social care is not new and has been the focus of many former policies and strategies, although the majority of these initiatives have met with mixed or limited success (Coleman, Checkland et al. 2014) and it is thought that HWBs ‘are likely to face similar challenges’ (Humphries, Galea et al. 2012:8). (Partnership initiatives are discussed in more detail below.) Others have voiced concerns that the ability of the new commissioning system to make an impact will be limited by financial pressures (Humphries 2013) and a loss of skills and expertise during the restructuring of services (Turner, Salway et al. 2013). There were also concerns regarding the likely effectiveness of HWBs as summed up by David Hunter in his evidence to the Health Select Committee:

‘I can see health and wellbeing boards being a repetition of what we had in the past, where they are glorified talking shops where people have no power to do anything, and then go back to their host organisations and life goes on unchanged.'
It’s another layer in the system creating significant transaction costs.’ (House of Commons Health Committee 2011)

This concern was supported by a simulation of the new system carried out in Lincolnshire, which found that the HWB was marginalised (Imison, Curry et al. 2011). Conversely, others are enthused by the opportunities HWBs offer for new and improved cross boundary working (Kidd 2011) and government expectations around the ability of HWBs to deliver have been high since the idea was first mooted (Behan 2011, Sillett 2012).

Given the novelty of HWBs, there are few empirical research papers available, although two projects have published findings of interest. The first (Humphries 2013 :10-11) looked at developing HWBs (but focussed on integrated care) and identified several factors thought to be instrumental in the success of HWBs. These include the role of LG, including health scrutiny, and the development and managing of relationships with health colleagues, especially where there are conflicts; the role of central government, and the need to recognise significant differences in the way that health and LAs operate; the need to focus on strategy and purpose and not structures; managing the HWB strategy and integration role tensions; and using influence rather than structure-based power. A separate early research project (focussing on CCGs) (Coleman, Checkland et al. 2014) found that there are local differences in HWBs, and noted significant challenges including lack of clarity around the role and the absence of powers leading to a reliance on relationships to achieve results. Practical issues were also found to be problematic, such as when and how often meetings should be held, who should sit on the HWB and who should chair it. Other issues identified were the effective representation of district councils in two-tier areas and the role of local HWBs. The findings of Humphries (2013) and Coleman et al (2014) are discussed later as they arise in the results chapters, as are the findings of a third report (Tudor Jones 2013), published by the right-wing think tank Localis which makes interesting recommendations around HWBs and partnership working. This is treated with caution, however, as it is not peer-reviewed, the methods described are extremely vague, it was commissioned and funded by Pfizer, and the section on LG control of private sector housing conditions shows a lack of understanding of the statutory powers available.
In a new development, Duncan Selbie, Chief Executive of Public Health England has signalled a proposed policy shift including a more coherent PH strategy with renewed emphasis on action to tackle the social determinants of health and a recognition of the limited role of the health service in prevention;

‘Together with Local Government, NHS England, the Department and others, we are in the early stages of developing a Health and Wellbeing Framework for England because we think it is important to have a single coherent narrative on the public’s health, the causes of ill health and inequalities and the need for far broader action than within the NHS alone. ....The narrative will acknowledge the international evidence that individual behavioural choices, our genes and the environment, such as jobs, decent homes and companionship, account for around 80% of the impact on length and quality of life; and that with some humility on our part we have been slow to recognise that they create the conditions for good health as a complement to healthcare, while at the same time decreasing the burden on hospitals and other health services. The statutory duty on upper tier and unitary Local Government to improve the public’s health, well beyond the confines of hospital and social care, provides the opportunity to move beyond the silos of the past.’ (Selbie 2013)

Linked to Duncan Selbie’s comments are those of John Ashton, President of the Faculty of PH and former Director of PH (DPH) in Cumbria, following the relocation of the NHS PH medicine function back to upper-tier LAs from health in April 2013 as part of the HASCA12, again recognising the PH role of LAs;

‘The natural links with public health in local government are in environmental health, housing, trading standards, education, recreation and regeneration’ (Ashton 2013 :29)

The relocation of PH medicine was seen as relatively uncontroversial, and whilst referred to, does not form a core part of this research. However the need to develop a ‘shared vision’ between transferring staff and their new LA employers is percieved to be important
(Kingsnorth 2013 :72, Coleman, Checkland et al. 2014) and is relevant to some of the findings discussed in later chapters.

2.2 Economic and political context
The research took place in a time of economic recession and central government policy of ‘austerity’ with significant public service cuts affecting local government (Abbott 2012, Hunter 2013). LA PH budgets have been ringfenced until 2016 (a decision received with mixed responses) (Wiggins 2013) and health and welfare budgets have also been affected by cuts (Humphries 2013, Reeves, Basu et al. 2013). A recent survey of senior LA managers indicated that in response to the financial situation 72.4% of respondents saw the future lead role of LG as a ‘leader of place’, compared to only 18.2% who saw the lead role as being ‘a champion of health and wellbeing within the community’ (Blyth 2013 :16), findings which could potentially impact the priority given to HWBs in future years.

There are three additional austerity-related issues that are pertinent to this research; the first is that HWBs were being established in a context of very little money to invest, including in their own development and support staff; the second is that the Conservative-led central government coalition vigorously blamed the previous Labour government for the economic situation and the austerity strategy they chose to adopt as a consequence (Ashton 2012); and the third is the known health effects of economic downturn. The political divide and health effects of political values in decision-making in particular had implications for both national and local politics, which is important because local elected members have a statutory place on HWBs, and one of the (disputed) claims for HWBs is that they would introduce democracy in health decision-making. Indeed, a paper has been published very recently (Scott-Samuel, Bambra et al. 2014 :54) linking the neoliberal policies of Thatcher (from 1979-1990) to ‘substantial increases in socioeconomic and health inequalities.’

The reasons for the economic downturn will not be discussed further here; however the health implications of recession and austerity policies are relevant and have received attention in recent literature, with particular concerns raised around the effects on health, health services and health inequalities (Pearce 2013, Stuckler and Basu 2013, Wood 2013). It has been noted that there are both direct and indirect effects of austerity policies on health; direct effects are those on health spending, whereas indirect effects are those on
social determinants of health, such as ‘increasing unemployment, poverty and homelessness and other socio-economic risk factors, while cutting effective social protection programmes that mitigate their risks to health’ (Reeves, Basu et al. 2013 :4).

Health inequalities are discussed in greater detail below, however the effects of the economic downturn on health inequalities are relevant here. Researchers from the Liverpool Public Health Observatory have identified several factors which they say separate the current economic downturn from previous recessions, these include falls in benefits (both unemployment and in-work) and earnings and the subsequent decline in living standards; new unemployment and worklessness; and changes in the nature of work including loss of job security and employment rights. They go on to say that the health effects of these manifest in stress, frustration-aggression (increasing violence and substance misuse); and actions to manage reduced incomes resulting in ‘time poverty’ limiting health-protecting activities (Winters, McAteer et al. 2012 :10). Others have highlighted the likely long and short-term health effects of the recession and austerity policies in London. Again, these include the effects of reduced incomes (including from welfare reforms) and higher unemployment, they also predict increased suicides, and perhaps homicides and increased domestic violence; an increase in the number of people with poor mental health; raise concerns around infectious disease outcomes, particularly for TB and HIV; and highlight issues around the health effects of poor housing and affordability (UCL Institute of Health Equity 2012). Both studies anticipate that the economic downturn will increase health inequalities and this prediction is supported by others who have noted the negative effects of recession and austerity policies on health (Barr, Taylor-Robinson et al. 2012, Stuckler and Basu 2013, Wood 2013) and in particular of the global economic downturn on suicide rates (Chang, Stuckler et al. 2013). Others argue that the health effects are more nuanced and, overall, there may be no effect (Pearce 2013). There are also some limited positive health outcomes predicted, such as a decrease in road traffic fatalities as people reduce private car use (UCL Institute of Health Equity 2012).

There is a body of literature on the links between PH and political values and conditions (Stewart 2005, Mackenbach 2013, Pega, Kawachi et al. 2013), including, for example, Bambra who cites Navarro’s findings that administration by political parties with
redistributive philosophies ‘tended to have better health outcomes than those with more neo-liberal governments’ (Bambra 2011 :746). This view was endorsed by Mooney who went as far as entitling the introduction to his recent book ‘Neoliberalism Kills’ (Mooney 2012 :3 ) and Pearce also argues that the UK Conservative-led coalition government has used the financial crisis to suggest a ‘crisis of big government’ and exploited the circumstances as a rationale for extending neoliberal ideologies’ (2013 :2030). In addition, a very recently published report by NHS Health Scotland commented on the health effects of neoliberal policies;

‘The impacts of recession (and the policy responses to the recession) may impact differentially across the population (e.g. by gender, income group, social class, disability). It has been found that countries which pursue active labour market policies and provide improved social and welfare protection have populations with better health than those which do not, and those which pursue neo-liberal policies (i.e. reduced market regulation, increased privatisation and decreased universality of welfare provision) tend to see health inequalities widen.’ (McCartney, Myers et al. 2013 :9)

Pearce’s (2013) comment on neo-liberalism in the UK, can be directly related to argument for the introduction of the HSCA12, in which much was made of the need for health reorganisation to cope with the spiralling cost of the NHS (Wood 2013) although Hunter (2013) states that ‘it has never been clear what the problem was to which the changes were presented as the solution’ he goes on to comment on why the central government pushed through such an unpopular piece of legislation;

‘Why the government should risk so much political capital by pressing ahead in such circumstances remains a puzzle. Unless, that is, one seeks to understand the political drivers behind the proposals. It is their ideological nature, and alignment with the government agenda committed to reducing the size of the state as an employer in order to create private sector jobs, which may hold the clue to the government’s dogged persistence to see its changes through’ (Hunter 2013 :12).
Others agree that the government did not make it clear what the need or purpose for the HSCA12 was (Timmins 2012:130).

The essence of arguments around neo-liberalism and poorer health outcomes centre on issues of power, social justice and societal and monetary inequality, and of individual responsibility against that of society as a whole. Whilst these factors are discussed in greater detail below, it can be seen at this early stage in the literature review that the role of local-level HWBs in mitigating the health impacts of an economic downturn and the central government adherence to a neoliberal approach and policy of austerity will necessarily be limited.

The political context, whilst only very lightly touched upon here is highly relevant to the research, as the central government is a Conservative-led coalition with the Liberal Democrats, whilst LAs included in the research were led by a variety of political parties, some of which changed in the May 2012 local elections. There are obvious tensions between central government financial and other policies which affect or inhibit LA health decision making by those with different political philosophies (Abbott 2012).

Although this thesis focuses on HWBs and the policy directly associated with their creation and operation, there are other policy elements which may also have an impact, primarily the value of localism. Localism is a key part of the coalition government’s agenda. In essence it means that decision making should be at a local rather than a central level; it is about decentralisation. Nick Clegg, Deputy Prime Minister has described it thus:

‘Of course, the Liberal Democrats and Conservatives use different language to explain decentralisation and to fight its cause. The prime minister has coined the phrase ‘Big Society’ whilst the Liberal democrats tend to talk about ‘Community Politics’, or simply just ‘Liberalism’. But whatever words we use, we are clear in our ambition to decentralise and disperse power in our society...’ (HM Government 2010)

This central government commitment to decentralisation is perhaps best seen in the Localism Act 2011, which gives a general power of competence to LAs to take action for local benefit, giving freedoms to ‘trade and charge’ (Local Government Association 2013).
The implications of this are that more power and freedom will be passed to LAs, which should then be passed on to empower local communities and individuals in their areas (HM Government 2010). Others raise the practical implications for a central government of pushing this agenda, pointing out that there will be political pressures and that it may ‘prove difficult for ministers to resist intervening’ where local decisions do not reflect the desired central direction (Staite and Miller 2011:2). Interesting recent examples of this prediction include the Local Government Secretary’s comments on the frequency of local refuse collection (BBC News 2012, Sustainable Review 2014) and banning the use of CCTV cameras by LAs for traffic enforcement (BBC News 2013).

A further concern with the rise of the localism agenda is that LAs are taking on additional duties at a time when they are experiencing severe funding pressures (House of Commons Health Committee 2011). Clearly, this could affect their ability to respond effectively to the proposed additional PH responsibilities and to utilise the freedoms in the Localism Act (2011) and the powers in the HSCA12. Staite and Miller, referencing the LGC, add that these large funding cuts ‘will have the greatest impact on the most deprived areas where health inequalities present the greatest challenge’ (Staite and Miller 2011:2).

The political element is a feature of LG service provision. McCarthy says that environmental health programmes are linked to the social and political systems of the communities in which they are carried out (McCarthy 1996) and this is also true of other local government functions, because LAs are led by elected members who are directly accountable to the local community via elections. One of the reasons often given for the relocation of PH to LAs is to restore the ‘democratic deficit’ of the NHS, in making decision-makers accountable directly to the public. The NHS Confederation considers that the presence of elected members on HWBs will not address the democratic deficit since they are not present on all the boards of commissioning bodies. They also argue that since the Secretary of State is responsible for the NHS, there is no existing deficit at a national level to be remedied (NHS Confederation 2011). As I have described, a consequence of giving elected members responsibility for decision making is that these decisions can become politicised. A further consequence is that local decisions will vary in different
areas. This is summed up neatly by David Hunter in his evidence to the Health Select Committee:

‘Don’t forget that this agenda is all about localism. Local authorities are different. That is the whole point about local government. They will vary in how they want to hold their DPH to account, but that is the price of localism. You are either for it or against it, but if you buy it, you have to buy what goes with it, which is variation and difference.’ (House of Commons Health Committee 2011)

Glasby et al, when discussing the speculative idea of transferring all PH functions to LAs, were of the opinion that this would increase interest in and turnout for local elections, but that elected members ‘may need considerable support and development to take on this new role’ (2010:256), and Weiss (1999) also highlights the difficult balance and tensions between democratic and expert decision-making. These observations indicate that the issues raised about the role of elected members within the new system are important. The enhanced role for elected members and associated local politics could perhaps lead to a resurgence of one or both of the opposite approaches of the ‘conviction politics’ of Margaret Thatcher and the commitment to ‘evidence based policy’ of New Labour described by Cookson, who is also of the view that the correct use of evidence based policymaking may ‘enhance open democracy and improve policy outcomes’ (Cookson 2005:119).

2.3 Health inequalities
Health inequalities are complex and enduring and have frequently been called ‘wicked problems’ (Hunter, Marks et al. 2010:158, Exworthy and Oliver 2012:291) in that they are difficult to address and overcome; or more controversially ‘for which there may be no solution’ (Allen and Rowse 2013:21). As the body of literature on the topic is vast and frequently contradictory, space constraints limit this section to an overview of the literature directly related to this research and does not cover inequity in relation to healthcare or access to healthcare facilities.

It is now widely accepted that there are links between mortality rates and age, gender, class and employment (Mitchell, Shaw et al. 2000) and that with some exceptions, poorer people
are associated with shorter lives and poorer health than richer people (Benzeval, Judge et al. 1995, Davey Smith 2003). This effect, known as the ‘health gradient’, occurs between and within every social class or socio-economic group and sees the people at higher positions experiencing better health than people at lower positions (Marmot and Wilkinson 2006). It is also known that advantaged groups are also experiencing faster health gains than less advantaged groups (Graham 2009) and some predict that there could soon be rises in mortality rates for certain disadvantaged groups (Dorling 2013 :8).

There is also a great deal of evidence to support the existence of health inequalities between social groups and in different geographical areas, linking health inequalities with place; for example, there is a North/ South divide in England, with people in the more affluent South living longer, illustrated by the 9.2 year life expectancy difference for males in East Dorset and Blackpool (Office for National Statistics 2013). Others have found ethnicity to be a determinant of health and inequalities (Karlsen, Nazroo et al. 2002, Rao, Chandra et al. 2010, Muennig and Murphy 2011). However health inequalities are expressed or defined, all the above evidence represents a great deal of avoidable suffering and many lost years; indeed it has been noted that ‘between 1.3 and 2.5 million extra years of life could be gained by reducing health inequalities in England’ (The Lancet Editorial 2010 :525). As Marmot says ‘Inequalities are a matter of life and death, health and sickness, well-being and misery’ (2010 :37).

Although the UK has measured, monitored and researched health inequalities for longer than any other country, Johan Mackenbach (2010) points out that the strategies tried so far have been largely ineffective. This was until very recently generally a consensus view; summed up by the White Paper ‘Healthy Lives, Healthy People: Our strategy for Public Health in England’ which states that

‘Health inequalities between rich and poor have been getting progressively worse. We still live in a country where the wealthy can expect to live longer than the poor’ (Department of Health 2010).

Recently, in response to Mackenbach following the release of updated population health data from the Department of Health, Bambra suggested that there was some partial
improvement in narrowing the health inequalities gap as a result of previous initiatives (Bambra 2012).

Unfortunately, a consensus definition of what ‘health inequalities’ are remains elusive. In ‘The Health Divide’, Whitehead offers a useful definition including the concept fairness in relation to tackling inequalities;

‘In health terms, ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, none should be disadvantaged from achieving this potential if it can be avoided.’ (1988 :222)

More recently, the WHO has stated that ‘The term ‘health inequalities’ refers to general differences in health. Many of these differences (particularly where they are linked to social variables or gender) represent ‘health inequities’ because they are unfair, unjust and avoidable’(World Health Organization Regional Office for Europe 2012 :15).

Unfortunately, to confuse matters, the terms equity and equality often appear to be used interchangeably in the literature. It is unsurprising that the term ‘health inequalities’ will mean different things to different people.

There are very many explanations offered for why health inequalities exist and Bartley (2004) helpfully describes four different models: behavioural and cultural; psycho-social; materialist; and lifecourse approaches covering a wide range of theories ranging from poor housing to cumulative life events. Other theories include the idea that the prolonged stress of a ‘social-evaluative threat’ creates a constant ‘fight or flight’ reaction, where cortisol is released, leading to physical effects including cardiovascular problems, obesity and psychological effects such as increased aggression (Wilkinson and Pickett 2010). An alternative but partly linked theory proposed by Scott-Samuel (2011) is that health inequalities stem from societal power inequalities. These include the neo-liberal capitalist system, the lack of emotional literacy in leaders and the patriarchal religious system which he says will prevent any progress being made in the current context and (as I have described earlier) others agree that the neo-liberal system is widening inequalities (Coburn 2004). There are many other theories relating to specific groups such as women, ethnic minorities and people living in certain geographical areas. In measuring these (and the
traditional class) factors, there has been criticism of the lack of information and routine recording of information required to measure health inequalities (Townsend, Davidson et al. 1988, Fulton 2010).

The ‘lifecourse’ approach was subscribed to by Marmot (2010) in his ‘Fair Society Healthy Lives’ strategic review of health inequalities and subsequently adopted by the current government (Department of Health 2010). Davey Smith (2003) states that this explanation of health inequalities began with the work of Forsdahl and later Barker, who initially considered that childhood malnutrition led to higher rates of coronary heart disease in adulthood. Davy Smith goes on to state that they later came to the conclusion that more powerful than childhood conditions was the nutrition experienced in utero. This led to the concept that the nutrition and conditions throughout life could affect health, which became known as the lifecourse approach.

Unfortunately, some explanations can lead to ‘victim blaming’, for example Pitts (1996) highlights the ‘Just World Hypothesis’, where it is believed that someone brings their own misfortune. She uses the stigma and blame attached to HIV/AIDS, and diseases arising from smoking and obesity as examples of this; differentiating between ‘innocent victim’ and ‘thoroughly deserving victim’. The Edwardian idea of the ‘deserving’ and ‘undeserving’ poor (Spear 2012 :121) and the concept of there being a ‘morality to poverty’ has recently re-emerged in some media reports (Wynne-Jones 2013) along with the ‘chav’ stereotype of the working-class (Jones 2011). Others have observed that the Coalition government have used ‘anti-welfare populism’ promoting resentment and a view of the poor as ‘other’ to enable cuts to the welfare system to be made (Hoggett, Wilkinson et al. 2013 :2). This idea is nicely summed up by Nathanson:

\[
\text{‘Inequalities attributed to sinful indulgence in wine and women are much less likely to interest penny-pinching public authorities than those attributed, for example, to the handle on the Broad Street pump’ (Nathanson 2010 :274)}
\]

The relevance of this phenomenon to the wellbeing agenda and the work of HWBs is evident in the potential impacts both on and of the decision-making of local elected members (and others) on the balance between individual responsibility and the role of
society in tackling health inequalities, and their consequent prioritisation and comissioning decisions.

2.3.1 Social determinants of health
Marmot and Wilkinson (2006) describe the ‘causes of the causes’ of health inequalities as the ‘social determinants of health’ using the example of smoking contributing to many diseases. The social determinants in this case would not be cigarette smoking, but the reasons why people smoke. Marmot identifies the following as key determinants of health:

‘...material circumstances, for example whether you live in a decent house with enough money to live healthily; social cohesion, for example whether you live in a safe neighbourhood without fear of crime; psychosocial factors, for example whether you smoke, eat healthily or take exercise; and biological factors, for example whether you have a history of particular illnesses in your family. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race. All these influences are affected by the socio-political and cultural and social context in which they sit’ (Marmot 2010 :39)

This theory recognises that many determinants of health originate ‘upstream’ and therefore need to be addressed at that level. Such policies by their nature require a multi-faceted approach across agencies and professional groups and are relevant to the role of HWBs; with some commentators predicting that services will be planned around the social determinants of health (Peate 2012). Bambra adds that previous policies and initiatives focus too heavily on ‘downstream’ measures and that an upstream approach needs to be maintained (Bambra 2012).

As we have seen, the causes of health inequalities are highly complex and they remain the subject of some speculation and ongoing research. As such, they are not straightforward either to define or address and there are difficulties in evaluating the short and medium-term effectiveness of interventions which may only be apparent in the long-term. Bambra cautions ‘the importance of time lags when measuring the effects of interventions on health inequalities, especially multiple interventions that may result in a combined effect over time’ (Bambra 2012 :662). These lags can cause problems where funding is based on short-
term outcomes and where the electoral system results in pressure to demonstrate policy impacts in one term.

Unsurprisingly, there are many suggestions as to what might work in tackling health inequalities. In the ‘Fair Society Healthy Lives’ review, Marmot suggests six policy objectives. These are:

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives
C. Create fair employment and good work for all
D. Ensure healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill-health prevention (Marmot 2010:93-149)

Interestingly, none of these priorities focus specifically on health care or adult’s services, reflecting two of the statutory members of HWBs. Many of the Marmot priorities are in the domains of professional groups with no statutory place on HWBs such as educators, welfare and benefit policy-makers, EH practitioners and planners.

The PH White Paper Healthy Lives, Healthy People: Our strategy for Public Health, (Department of Health 2010) explicitly accepted Marmot’s approach, however this did not include a commitment to the healthy standard of living objective, which relates to minimum income and other financial matters. There is significant support from others on the need to tackle poverty, for example, Mitchell, Shaw and colleagues (2000) consider that the number of premature deaths in Britain would decline if there was full employment, a modest redistribution of wealth, and an end to childhood poverty. There is a difference, however, between improving the economic circumstances of the poorest people and creating economic equality in a society and Bosma (2009) suggests that policymaking for equality may have more of an impact on general health and poverty reduction than health inequalities, citing genetic and cultural issues as also being important.

There have been several critiques of the Marmot review and its recommendations, although these appear to have come from academics rather than practitioners. Several commentators
have criticised the vagueness of recommendations, particularly at the national level (Whitehead and Popay 2010) and others have raised concerns at the focus on individual empowerment to ‘take control of one’s life’, which is in contrast to upstream measures promoted elsewhere in the review and ‘is by no means a guarantee of good health’ (Nathanson and Hopper 2010:1238). Whitehead and Popay (2010) were unimpressed by the focus on action at a local level and also that the role of political power and other wider factors were overlooked (Subramanyam, Kawachi et al. 2010). Pickett and Dorling also felt that significant omissions were the failures to promote wider changes in UK society and ‘to deal with the need to reduce inequality by focussing on the top end of the social hierarchy, as well as at the bottom’ (2010 :1231), and they ask ‘Why did the Marmot review not make hard-hitting recommendations to reduce the harm created by great differences in rank and status?’(Pickett and Dorling 2010 :1233). Concerns have also been raised that the review did not address ethnic factors in health inequalities (Fulton 2010) and the economists Chandra and Vogl (2010) provide a detailed critique of the evidence used to support some of the claims of causality in the review. Finally, others hold the view that a downstream focus on healthcare can have a great impact in tackling health inequalities (Nathanson 2010), particularly by targetting the most disadvantaged during early childhood (Canning and Bowser 2010).

Very recently, the British Academy asked nine academics to suggest LA action to reduce health inequalities. Their suggestions were; introducing a living wage, reducing speed limits, focussing on early childhood, tackling worklessness, focussing on mental health and capacity, using further and adult education, looking at ethnicity, developing older age-friendly environments, and basing decisions on good evidence and evaluation (Pickett, Melhuish et al. 2014). The King’s Fund have also recently produced a resource pack for LA public health prioritisation (Buck and Gregory 2013), however no such guidance was available during the early shadow stages of HWBs.

2.3.2 Action to tackle health inequalities
Prior to Marmot’s review, The Black Report (Townsend, Davidson et al. 1988) specifically listed improving working conditions and housing as necessary to tackle health inequalities. Evans and Killoran (2000 :136) agree that ‘health strategies and programmes need to
address such ‘upstream’ determinants of health as poverty, unemployment and poor housing if the health of the worst off in society is to be improved’. The (New) Labour government, elected in 1997, accepted that there were many social determinants of health and focussed polices on addressing a broad range of these (Uberoi, Coutts et al. 2009) however, the results cannot realistically be measured in the short to medium term (Sassi 2005) as outlined by Bambra above.

As would be expected, there are many suggestions as to what might work in tackling health inequalities. For example, Mitchell, Shaw and colleagues (2000) consider that the number of premature deaths in Britain would decline if the economic factors such as full employment, redistribution and ending childhood poverty were addressed. The idea of poverty reduction as a means to tackling health inequality seems to have widespread academic support (Benzeval, Judge et al. 1995) although this was not reflected in the PH White Paper (Department of Health 2010). Margaret Whitehead cited by Benzeval et al (1995) suggests that policies can reduce health inequalities at four levels, by:

- Strengthening individuals
- Strengthening communities
- Improving access to essential facilities and services, and
- Encouraging macroeconomic and cultural change

Researchers have discussed many other factors. For example, some research indicates that in more equal societies, there is less ill-health and fewer social problems (Wilkinson and Pickett 2010) and others agree that action on social and economic justice in society is needed to address PH issues (Labonte, Frank et al. 2008). Others argue that apparent equality could be masking other inequalities such as between men and women (Bartley 2004). Fulton (2010) also notes that although many governments have published strategies aimed at tackling health inequalities; the majority have focussed on socio-economic factors, omitting to consider ethnicity as a significant factor.

It is evident that there is no agreed approach to tackling the causes of health inequalities. Some say that economic redistribution (Sassi 2005) would address the issue, whilst others argue that education (Blaxter cited by Bartley (2004) or direct health interventions
(Canning and Bowser 2010) are the answer and proponents of the lifecourse approach stress the importance of action at different life stages (Marmot 2010). Nevertheless, it can be seen that the causes of health inequalities are complex and multi-factorial and only a minority can be addressed by the health service (Asthana and Halliday 2006). The Environmental Health Commission (EHC) (MacGibbon, 1997:3) adds to this, describing the uniting of environmental and PH necessary for future success in tacking the wider determinants of health as being ‘bottom up’ with the strong involvement locally of members of the public.

In developing social and economic policies to tackle inequalities, it is important to note that options for improving population health in general may do nothing for closing the gap in health inequalities. Sassi (2005) points out that the Labour government controversially held the view that by increasing overall population health, this would reduce health inequalities as those most in need would be the greatest beneficiaries. He contrasts this approach with that of the previous Conservative administration, which relied on an economic recovery based on a ‘trickle down’ strategy. A review paper looking at the success of government reviews in reducing health inequalities found that ‘reforming left-leaning governments are more committed to long-term monitoring of inequalities, even if the results are not always politically comfortable’ (Howden-Chapman 2010 :1242). This observation is useful for this project, given the emphasis on localism and the role of elected members in the new PH system.

As we have seen, the reasons suggested for health inequalities are complex and this is recognised by NICE guidelines which add that social and material circumstances can affect the abilities of individuals to change or modify their behaviour (National Institute for Health and Clinical Excellence 2007). Connected to this is a need to look more closely at the ‘causes of the causes’ or the reasons why certain behaviours are practiced (Standing 2011) There is also a concern that the current enthusiasm for ‘nudge’ could widen health inequalities, as different members of society will (be able to) respond in different ways.

The concept of nudge is built around offering a ‘choice architecture’, where individuals are encouraged, often covertly, to make ‘good’ decisions, whilst still having the option of selecting ‘bad’ ones (Thaler and Sunstein 2009 :89). Proponents of this approach also
referred to as ‘behavioural insight’ argue that this ‘libertarian paternalism’ approach is a
low-cost way of improving population health, whilst maintaining individual liberties, and
therefore acceptable to the political right where ‘nannying’ is unpalatable. However, the
claim of preserving individual liberties is arguably not strictly true, when the intention is to
manipulate behaviour, and others highlight the role of powerful industries in talking down
the ‘nanny state’ and preventing necessary action on PH issues (Wiley, Berman et al.
2013). Thaler and Sunstein (2009) also cite existing examples of nudge used to promote
driving instead of walking and the consumption of unhealthy foods and excessive alcohol
(Marteu, Ogilvie et al. 2011) (Bonell, McKee et al. 2011). Examples given by the Cabinet
Office of case studies ‘applying behavioural insight to health’ are the introduction of the
national food hygiene rating scheme, which provides inspection information to consumers;
a mentoring scheme for likely teenage mothers to spend time with toddlers; changing
‘norms’ of drinking by publicising low average consumption to university students; and a
smoking cessation trial with Boots the chemist (Cabinet Office Behavioural Insights Team

Opponents of the approach argue that it is unethical to try to change behaviour without the
consent of the individuals involved; that it is coercive and rewards ‘bad’ behaviour (Oliver
and Brown 2011); and that it changes motivation from acting for the reason of ‘doing the
right thing’ to acting because a (monetary or other) reward is offered. Additionally, there
are concerns around equity, where ‘nudges’ or ‘conditionality’ are targeted only at certain
groups of people, for example those on low-incomes rather than applying across society.
Tied to this is the notion that some people are more ‘deserving’ than others (Standing 2011)
and here we have a link to the ‘victim blaming’ discussed above. Bonell et al argue that

‘the government had misrepresented nudging as being in opposition to their use of
regulation and legislation to promote health, and that this misrepresentation serves
to obscure the government’s failure to propose realistic actions to address the
upstream socioeconomic and environmental determinants of disease’ (Bonell,
McKee et al. 2011 :11)

Others point out that the evidence of nudge for positive behaviour change is weak (Marteu,
Ogilvie et al. 2011).
The concept that health improvements cannot be made solely by medical means or by relying on an individual’s sense of personal responsibility is not a new discovery. MacGibbon (1997) notes that McKeown found in the 1970s, that improved mortality rates (the smallpox vaccination aside) from 1840 onwards were due to limiting family sizes; food supplies; and environmental improvements made possible through general economic growth. Whilst this view is well recognised, it is challenged by Szreter (1988) who contests economic growth as being beneficial and emphasises the role of LG in securing improvements. Clearly, neither argument supports the role of medicine as the main driver in improving population health.

The work of Marks et al (2010) identified a tension between the collective and the individual in focus groups discussing the new PH arrangements. In treating society or a group of people as a unit, the behavioural approach can be contrasted with the ‘collective protection’ approach mandated in legislation and guidance in the field of occupational health and safety, arguably a key area of PH practice. To illustrate, the majority of regulations now explicitly require that collective measures protecting all individuals take precedence over individual controls. This approach recognises that reliance on human behaviour is untenable, indeed, investigations into many serious incidents have found ‘human factors’ to be the major causes of several very serious incidents, for example Piper Alpha, Chernobyl, Bhopal, Kings Cross and Zeebrugge (Health and Safety Executive 2005).

Additional examples of where a collective approach has successfully been taken to protect PH include the introduction of the Clean Air Acts; requiring the provision of potable water; and most recently the ‘smoke free’ legislation. Other examples of effective societal approaches are the criminalisation of drink driving, introduction of car MOTs and the requirement to wear a seatbelt; all demonstrate that legislation can effectively change lifestyle behaviour (Kopelman 2011). Such approaches are also useful where the necessary action cannot be taken by those who are affected, for example with food hygiene standards in commercial premises and protection for homeless people. All the above are situations where changes have been mandated for the collective good of society, although clearly this
approach is not appropriate in all situations and a balance must be made with individual liberty. Arguments for the use of legislation in PH can be summed up as follows:

‘Legislation can appear to be a simple and powerful tool, and the evidence suggests that introducing legislation, in conjunction with other interventions, can be effective at individual, community and population levels’ (National Institute for Health and Clinical Excellence 2007 :8)

The Nuffield Council on Bioethics’ ‘intervention ladder’ was included in the PH White Paper and describes a stepped approach to interventions, with legislation being seen as a ‘last resort’ when the other steps have been exhausted (Department of Health 2010). Assertions against the use of regulation in PH can be summed up by the following quote;

‘strong-armed regulation is not the answer to rebalancing our diets, changing our desire to drink too much alcohol on a Friday night, or making our lives more active’ (Cabinet Office Behavioural Insights Team 2010 :6).

Whilst initially, and as discussed above, it seems that these approaches could be complimentary, Asthana and Halliday (2006) contribute a topical observation, pointing out that right wing policies for addressing health inequalities tend to focus on the choices of individuals whereas left wing policies see poorer health as the outcome of the material circumstances of certain groups. HWBs, in developing their JHWBS may be influenced by current debate on the most effective way to tackle the social determinants of health, particularly in changing the behaviours of individuals and populations. Linked to this is the ‘MINDSPACE’ work commissioned by the government in effecting behaviour change for health (Dolan, Hallsworth et al. 2010).

Both nudge and enforcement or regulation have their proponents and it has been argued both that the approaches are mutually exclusive and also that they are not (Bonell, McKee et al. 2011). The original definition of nudge excluded legislation (Marteu, Ogilvie et al. 2011) but legislation was used in examples listed by the originators of the idea in their book (Bonell, McKee et al. 2011). The background literature on nudge and political attitudes to enforcement and regulation are important for this research, which focusses on the role of environmental health, which is primarily a regulatory PH occupation.
Prof Chris Bentley has expressed concerns that HWBs might be too ‘pink and fluffy’ and may lack ‘firmness or stiffness of spine’ to make an impact on health inequalities (O’Dowd 2013 :1), whilst others felt that ‘there is always the danger that HWBs will end up as talking shops’ (Sillett 2012 :710). What is clear is that HWBs will be very limited in the regulatory tools available to them, with the exception of those already in existence, for example to local planners, building control officers and EHPs operating in LG regulatory roles. Some commentators have described a general pessimism about the ability of GPs to commission at a population level and have raised concerns about the possibility of a ‘piecemeal’ approach and ‘reduced commitment to a health inequalities agenda’ (Turner, Salway et al. 2013 :1).

2.4 Environmental health as a public health occupation

In June 2011 Zsuzsanna Jakab, WHO Regional Director for Europe endorsed Acheson’s 1988 definition of PH as

‘the science and art of preventing disease, prolonging life and promoting health through organised efforts of society’ (Jakab 2011 :4).

She went on to say that one of the greatest public health challenges in Europe today is the ‘unequal distribution of health and wealth’ (Jakab 2011 :3), a comment which puts the issue of health inequalities centre stage in the PH field. Given that the HSCA12 has seen the relocation of PH medicine to LAs, and also that this research focusses on EH as a PH occupation, a short appreciation of the historical context of PH is useful.

The historic field of PH medicine spans both the NHS and LG; in the mid-1800s being the function of LG-based Medical Officers of Health (MOH), assisted by sanitary inspectors (Betts 1993, Hamlin 2013) (formerly inspectors of nuisances (Hatchett, Spear et al. 2012, Hamlin 2013) and later known as public health inspectors, then EHPs). Betts cites Johnson who provides a telling quotation from a President of The Sanitary Inspectors Association describing the early days;

‘It was soon found by experience that the medical officer of health required a working hand, since it was impossible for him to go from his office to inspect every
danger to health. In this way sprang up the sanitary inspector... His duties were laborious, his salary contemptible. I designated him, in his first days, as the Forlorn Hope of Sanitation.’ (Betts 1993 :47)

PH remained in LAs until the 1974 reorganisation (Griffiths 2003). This controversial reorganisation split PH and left LAs with EH (Allen 1991) in addition to social workers and many other functions affecting the wider determinants of health. The Second Report of the Parliamentary Select Committee on Health (2001) helpfully sums up the detail and some of the consequences of the reorganisation:

‘The post of MOH was abolished in 1974 and the responsibility for monitoring environmental determinants of health passed to Directors of Environmental Health who were employed by local authorities. Doctors trained in public health medicine became Community Medicine Specialists employed by health authorities to monitor the health status of the population and advise health authorities on how best to tackle the health problems of their community. Before 1974, the MOH had responsibility for the provision of some personal health services and in addition, was able to influence, as an officer of the local authority, social and environmental aspects of health. These functions were lost as a result of the transfer of the MOH into the Health Service...’ (House of Commons Select Committee on Health 2001: 27)

As I have described, prior to the reorganisation, MOH were administratively responsible for sanitary inspectors and Cornell suggests that ‘the initial disparity in status and education between the MOH and the nuisance officers sowed the seeds of rivalry and resentment’ (Cornell 1996 :74). This separation of the disciplines has increased over the years, as MacGibbon Chairman of the Environmental Health Commission (EHC) points out that ‘health’ and ‘environment’ have ‘drifted apart, both conceptually and in our institutions’ (1997 :2). She notes that health policy has tended to focus on treating ill-health, whilst environmental policy has broadened, and at times, moved away from health issues and Cornell agreed, noting that EH and NHS PH departments had very little contact (Cornell 1996). This view follows Lewis (1986) who noted ten years earlier that there was an absence of a clear philosophy and direction in PH. The EHC concluded that the divergence
between medicine and environment needed to be reversed in recognition of the wider determinants of health and went on to recommend that environmental health and PH are linked again at a local level and better co-ordinated at higher levels (1997:3).

In the 1980s the ‘New’ PH movement emerged which focussed on the social determinants of health, recognising that the role of the medical professions in improving PH is limited and expensive, and also noting the role of ‘environmental factors’ on health (Ashton and Seymour 1988). Green and Thorogood, cite Action and Chambers who said ‘this is not without irony for the present day environmental health officers, who feel that this is what they have been saying and doing all along, but without the benefit of either a medical degree’s status or indeed its salary!’ (1998 :32)

Twenty years ago, Betts described EH as the local government ‘service department which is most closely associated with health... Almost all of its duties have an impact upon health’ (Betts 1993 :129). Whilst the duties have not significantly changed in the intervening years, recognition of the health role appears to have diminished when considering the lack of a statutory role in the new HWBs, which are aimed at joining up healthcare and LG services to improve PH. At around the same time, Allen noted that EH was, seemingly, in a ‘good position’ as ‘health professionals within the elected LA’, however he raised concerns that this potential would not be realised due to policy shifts at that time away from LG (Allen 1991 :142). Betts (1993 :79) also noted that EH had not ‘developed an independent and critical voice or developed a wider role’, and he said that this was partly because of government restrictions both at central and local levels. He also noted that EH had not risen to its potential in tackling health inequalities and had failed to take the necessary strategic role in health promotion (1993 :72). This very brief overview has shown that historically PH has been fragmented, there has been rivalry between occupational groups, and in recent years, a lack of direction.

Rayner and Lang have recently stated that PH ‘suffers from cultural invisibility’ (2012 :4) and others have described the political invisibility of PH and the linked concern about the effectiveness of regulation (Burris 1997). Rayner, Lang and Burris have all described an ‘ecological’ idea of PH, where the role of the environment is recognised; and Morris says that the 21st Century is an era of ecological PH where ‘everything matters’ and he calls for
consistency across different policy areas, for example in tackling climate change. Specifically, he notes ‘a desire to move beyond the prevailing rather narrow, compartmentalised and hazard-focussed EH ethos to one that recognised a wider potential for environmental change in prompting positive health and wellbeing’ (Morris 2010 :37) Lang and Rayner ask if PH is becoming ‘a technocratic localised act’ and predict ‘irrelevancy’ if this is the case. They call for large scale thinking and a ‘political[ly] savvy’ ecological PH approach (Lang and Rayner 2012 :2) whilst Evans cautions that it is not always easy for ‘macro-level theorising to be translated into real-world practice’(Evans 2013 :124). Finally, others have called for a ‘fifth wave’ of PH, where the emphasis is shifted away from economic growth and individualism towards a more positive, co-operative and future-conscious approach (Hanlon, Carlisle et al. 2011 :34-35).

Today, EH encompasses a wide range of functions and the WHO definition is a good reference point in describing the contemporary role:

‘Environmental health addresses all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviours. It encompasses the assessment and control of those environmental factors that can potentially affect health. It is targeted towards preventing disease and creating health-supportive environments. This definition excludes behaviour not related to environment, as well as behaviour related to the social and cultural environment, and genetics.’ (World Health Organizaton 2011)

Within this, core functions in England include dealing with housing standards; food safety; health and safety; air pollution control; contaminated land; and control of statutory nuisances such as noise, dust and odour. Additional functions might include imported food control in port areas; licensing; food standards; statutory burials; health promotion; and enforcing ‘smokefree’ legislation. EHPs are one of very few PH occupational groups with a regulatory role and statutory powers, for example being able to serve various notices including for improvement, seizure, detention, and prohibition and to take criminal prosecutions. Their wide remit has also led to them being referred to as the ‘general practitioners of public health’ (Cornell 1996 :74).
The role of EH inequalities, whilst not well recognised in England is well acknowledged at
the international level, with the WHO publishing a substantial report noting that EH
inequalities existed in the whole of the WHO European region, and calling this a matter of
‘environmental justice’ (World Health Organization Regional Office for Europe 2012 :16).
The report focussed on housing, injury and environment-related inequalities and ironically
a significant contributor was George Morris, a Scotland-based academic with a background
as a UK EHP.

Figure 3 shows how UK environmental health functions fit with Marmot’s policy
objectives C, E and F, and his recommendations (Marmot 2010). (The routes to
qualification and networks in EH are discussed in chapter 11.)
C) Create fair employment and good work for all

2) Implementing guidance on stress management and the effective promotion of well-being and physical and mental health at work

- health and safety
- health promotion

E) Create and develop healthy and sustainable places and communities

1) Improving the availability of good quality open and green spaces across the social gradient

- Improving the food environment in local areas across the social gradient

- Improving energy efficiency of housing across the social gradient

2) Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality

- all functions
- pollution control
- food safety and standards
- housing

F) Strengthen the role and impact of ill-health prevention

1) Prioritise investment in ill health prevention and health promotion across government department to reduce the social gradient

2) Implement an evidence-based programme of ill health preventative interventions that are effective across the social gradient by:

- focussing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient

- improving programmes to address the causes of obesity across the social gradient

3) Focus core efforts of public health

- all functions
- health promotion
- licensing
- food safety and standards
- health promotion
There are commonly said to be 3 domains of PH. These are:

- Health improvement
- Health protection and
- Improving health services

(Faculty of Public Health 2011).

It is accepted that EH has a ‘crucial role’ in the first two aspects and there were concerns at the consultation stage that this role should not be diminished by the provisions of the HSCA12 (Faculty of Public Health 2011:8). In addition to the introduction of the HSCA12, other policy areas have also impacted upon EH, particularly in terms of a diminution of the regulatory role as part of the ‘Better Regulation’ agenda, ‘Red Tape Challenge’, and ‘Focus on Enforcement’ and other similar initiatives. In response, David Kidney, Head of Policy at the Chartered Institute of Environmental Health said

‘Let us just remind ourselves that in a civilised society regulation is valuable for public protection, supporting enterprise and growth, improving public health and wellbeing and helping to tackle climate change including the promotion of sustainable development. This constant negativity is harmful to morale, performance and public respect for regulators. It is time that ministers saw this.’ (Wall 2012)

Academic commentators have also criticised ‘the government’s ideological war on enforcement’ raising concerns at the the growing trend of under rather than over-enforcement (James, Tombs et al. 2013:49-50), and Day cites Prof Hugh Pennington as stating (food hygiene) ‘inspections should not be regarded as a burden’ (Day 2011:62).
2.5 Evidence based policy and practice

Evidence based policy and practice have become increasingly important ideas in medicine and PH. Cookson (2005:119) provides a useful differentiation between evidence based medicine (EBM) and evidence based policy in healthcare, whilst recognising that they are similar concepts. He defines EBP making as that which ‘focuses on public policy decisions about groups of people rather than decisions about individual patients’. Using this definition, it could be argued that evidence based PH is strongly related to evidence based policy in general, since the discipline is concerned with populations rather than individuals.

Qualitative approaches in research can be useful when developing evidence based policy: Several academics (Pollitt, Harrison et al. 1990, Cookson 2005) have commented on the need for a qualitative approach when researching policy, where randomised controlled trials and other ‘experiments’ are not possible. However, qualitative research may not be designed to influence policymaking, with some academics making clear that the main aim of their work is not to make ‘practical recommendations for action’ (Pollitt, Harrison et al. 1990:182) and research may not be written in a ‘user friendly’ way for practitioners to utilise. Others have found a general lack of assessment of health technology in PH and speculate that this could be because ‘they are inherently more complex…[and]… ‘are usually multisectoral, politically charged and often considered mundane and ‘common sense’ and, thus, not requiring evaluation’ (Holland 2004:77). What follows is that accessing research, drawing conclusions and making generalisations for use in future policymaking is not straightforward; creating an evidence base for policymaking and PH is trickier than creating one for medicine, however Stuckler and Basu (2013) argue that evaluating public policies is vital for effective and informed democratic decision-making.

Even where there is evidence for policymaking, it has been found that ‘there is a considerable gap between what research shows is effective and the policies that are enacted and enforced’, and Brownson et al go on to identify eight ‘barriers to implementing effective public health policy’:

- Lack of value placed on prevention
- Insufficient evidence base
- Mismatched time horizons
- Power of vested interests
- Researchers isolated from the policy process
- Policy process can be complex and messy
- Individuals in any one discipline may not understand the policymaking process as a whole
- Practitioners lack the skills to influence evidence based policy

(Brownson, Chriqui et al. 2009 :1576-1577).

Marks (2006 :67) adds that similar barriers exist in using evidence to tackle health inequalities; citing a lack of evidence, ongoing theoretical debates, and the type of evidence (avoiding focusing on simplistic, easy to measure issues) as important considerations.

An additional challenge is that PH interventions often require a long term commitment, for which progress can be difficult to measure in the shorter term and that expectations for results in a given time period can be unrealistic (Bauld and Judge 2008). Jo Webber, Deputy Policy Director of the NHS Confederation summed these difficulties up in her evidence to the Health Select Committee;

‘There are some proxies you could use for the short-term- and by short-term I am meaning one, two or three years- but, with some public health interventions, it is going to take you 10 or 20 years before you see what that outcome might be, by which time you are going to have had probably two or three changes of idea about which way this is all going. Therefore, it is about getting the right proxies in place as well in the short term and then allowing the evidence base to be built.’ (House of Commons Health Committee 2011)

Greenhalgh and Russell (2009 :310) argue that an EBP approach will not identify ‘what the right policy is for every particular situation’, as this depends upon the judgements made in framing ‘the problem’. They say that ‘political problems are turned into technical ones, with the concomitant danger that political programmes are disguised as science’ and others note that, with regard to Health Action Zones, ‘early wins’ were targeted for political expediency (Bauld and Judge 2008 :93). Rayner adds that a new approach to PH is needed ‘..beyond the timid evidence based perspective’ going on to say that evidence is useful, but
needs to be seen as a resource rather than a limitation (Rayner 2007 :454); and Tannahill promotes ‘making decisions in good faith’ which recognises the roles of evidence, theory and ethics in public health decision making (Tannahill 2008 :380). These observations are extremely pertinent to the emphasis on local democracy in the current political agenda, the development of strategies of HWBs to tackle health inequalities, and the position of EH.

Observers have recently noted that linking funding for health promotion activities to evidence based practice is ‘now the norm’ (Dunne, Scriven et al. 2012 :109) however they raise concerns that the evaluation of work to create evidence which informs future work requires investment. They also note, as I have described above, that evaluating health promotion initiatives is not straightforward and medical ‘gold standard’ approaches, such as the randomised controlled trial cannot be utilised in many community situations.

Scriven asks ‘what counts as evidence and what methods are appropriate in measuring intervention effectiveness?’ (2012 :108) and these are potentially important issues for the future of EH in the new PH health system; and others consider that ‘what is counted as evidence, and methods for gathering and synthesising evidence, will need to be substantially broadened’ (Marks 2002 :44). A very recent survey of people working in PH found that there were concerns of bias in evidence, different understandings of what constitutes evidence, and issues around access to resources (UK Health Forum 2013). The access issue is very real for LA-based occupations, as traditionally LAs have not subscribed to services allowing access to peer-reviewed journals (Couch, Stewart et al. 2012). There are some hopes that this will change as a result of the relocation of formally NHS-based PH practitioners, who would have had access in their previous roles and expect this to continue.

The UK Environmental Health Research Network (EHRNet) have defined evidence based environmental health as;

‘...environmental health policy and practice supported by the best available evidence, taking into account the preferences of citizens and the wider public and our own professional judgment.’(Barratt, Couch et al. 2013 :2)
They add that the interdisciplinary nature of EH adds complexity, which is an asset but also a vulnerability in that there is a lack of a ‘home and body of knowledge’ (Barratt, Couch et al. 2013:2). Day (2011) acknowledges the work of Schon when he notes that ‘the firm high ground presents the problems that are immediately solvable through the application of well-understood theory and practice, but are relatively unimportant in the grand order of things, and the ‘swampy lowlands’ which contain problems which are ‘messy and confusing’ but are of far greater importance to society and the objectives of the profession’ and this illustrates some of the issues in developing a body of useful EH evidence.

There is no academic research centre for EH in the UK; with the few EH academics that do exist generally employed in health or social services faculties or alternatively in law, housing or food faculties, depending upon their specialism and interests. Environmental health practitioner-researchers remain rare, which was one of the drivers for establishing EHRNet. This rarity may be linked to the practice of lecturers on EH courses being recruited for their practitioner skills rather than their research abilities or experience, and consequently EH teaching departments do not often have a strong research base from which to teach students or to encourage and prepare them to contribute to EH research and publication once qualified. Whilst this is only a brief overview of the literature, understanding the issue of EBP in EH is fundamental to appreciating the findings of this research in their context.

2.6 Local government in England
As I have described, the role of LG in PH is changing. Whilst the literature is extensive and cannot be fully discussed here, an understanding of how authorities are structured and operate is crucial to appreciating the differences between the health service and other organisations, and also in understanding the findings of this research.

The organisation of LG is complex and can be confusing. In the majority of cities and some counties, authorities are described as ‘unitary’, that is, all functions are carried out by one body. In other areas, there are two tiers, with some functions, such as social services, education, trading standards and highways sitting at the upper-tier, whilst other functions such as environmental health, building control and planning sit at the lower-level. These terms can be misleading as upper-tier authorities do not have any jurisdiction over district
and borough councils and indeed the latter prefer to be called ‘district councils’ (Gray 2013); all are independent organisations, although they do work closely where beneficial, for example in emergency planning and food standards (Bassett 1995).

LAs are ‘creatures of statute’, that is, they exist to carry out specific functions prescribed in law and are ‘a provider of services to a local community and an instrument of democratic self-government, not a mere agent of the state’ (Redcliffe-Maud and Wood 1974 :10) a description which is important when considering the ‘localism’ agenda described above. They are controlled by locally elected members (councillors), usually one for each ward or parish and just as in central government, party politics play a significant role; a development which has increased since the 1970s (Wilson and Game 2006 :303).

Councillors may be independent or stand as members of a political party or other interest group (Leach 2004). Typically, the turnout for local elections is low (Wilson and Game 2006 :225), at times as low as around 40% (Byrne 1994 :137) and there is a general ‘indifference and disinterest’ in local politics (Pratchett 2004 :215). This apathy also relates to elected members and has been described by Michael Heseltine, cited by Byrne (1994 :177) as ‘it’s getting harder to attract people to serve on councils. Not just the people of the necessary calibre- it’s often difficult to attract anyone at all’. Pratchett also lists four reasons why ‘local politics does not work’, these are; public indifference, elected members not being representative of the communities they serve, poor links with partners and the community, and their paternalistic approach (Pratchett 2004 :219-220), and all of these factors could potentially play a role in the operation of HWBs.

Councillors make key decisions on budgets and strategy and are guided by officers, who are responsible for day to day management (Bassett 1995). This distinction between roles has been described as useful but simplistic and other theories or models suggest that officers hold the balance of power or that decision making is balanced between elected members and officers (Wilson and Game 2006 :319-322) or that there is a ‘dynamic dependency’ between them even where the vision or agenda is not shared (Gains 2004 :95). Whichever model is subscribed to, it is clear that the relationships and power balance between officers and elected members can be nuanced and complex (Gains, John et al. 2008). This is very important given the unusual membership of HWBs, where councillors
and officers have equal voting rights, and will necessarily need to switch to their former roles for other duties.

HWBs are essentially council sub-committees (situated in upper-tier authorities in two-tier areas) and a consultation document on the HSCA12 explicitly stated ‘we propose an enhanced role for elected local councillors and LAs, as a more effective way to boost local democratic engagement’ (Department of Health 2010). The use of HWBs as a means of decentralisation and including the role of local elected members fits with the ‘political decentralisation’ model described by Pollitt, Birchall and Putman where the shifting of responsibilities or authority to LG is given as an example (Pollitt, Birchall et al. 1998 :6). This change could potentially introduce an overtly political element to the work of the HWBs and as I have described, policies are extremely variable according to the political persuasion of their makers.

Wilson and Game (2006 :122) have categorised local services into four types; Needs (such as education, benefits and social care); Protective (such as police, fire and emergency planning); Amenity (such as planning, highways and environmental health); and Facility (such as housing, libraries, leisure centres). In my view, some EH roles would also fit well into the protective category; and whilst the model includes functions not carried out by LAs, it nevertheless provides a helpful overview of the breadth and complexity of different LA functions and roles.
The figures below show typical functions of the upper and lower-tiers in a two tier LA system. Unitary authorities carry out all functions listed.

**Figure 4 Simplified typical County Council (upper-tier) functions**

**Figure 5 Simplified typical District/ Borough Council (lower-tier) functions**
The role of LG in health has been recognised for a long time, and Wilson and Game (2006:134) describe the situation after the 1974 restructure ‘..leaving it with ‘only’ environmental health, although this responsibility still gives councils -as employers, service providers, regulators and community leaders -far greater health promotion and disease prevention potential than any other institution, including the NHS itself.’

In March 2013 the Communities and Local Government Committee published its report on the role of LAs in health which acknowledged their role in prevention and tackling the social determinants of health, and noted that work across all services is needed (House of Commons Select Committee on Health. Communities and Local Government Committee 2013). It is clear that there are many functions in both LA tiers, which can have an impact on the social determinants of health. The Improvement and Development Agency (I&DeA) has carried out a substantial piece of work entitled ‘The social determinants of health and the role of Local Government’(Campbell 2010) which looks at many of the factors discussed in this research. Of particular interest is the chapter by Dorling in which he talks about ‘place shaping’ which proposes an alternative view of LG which moves away from focussing on the statutory delivery of individual services towards ‘a unit of government, responsible for the well being of a community and a place, and independent of, whilst also being connected to, the wider system of government’(Dorling 2010:16). This alternative view fits well with the idea of the HWB as a forum for the health and wellbeing of a geographical area across services; and organisations and recent work on place shaping, including Health Impact Assessment in the North East found that the approach ‘can offer real strategic advantages’ in relation to understanding the wider determinants of health locally (Learmonth and Curtis 2013:22).

2.7 Local government and health services- partnerships and joint working

Following the major health service and LA restructure of 1974 various efforts have been made to encourage joint working towards common goals (Evans and Killoran 2000, Smith, Bambara et al. 2009) with several policies promoting partnership working between these organisations (Coleman, Checkland et al. 2014). Joint working was mandated in the Health Act 1999, which requires that NHS bodies and LAs cooperate to improve the health and welfare of the population. However, partnership working between LAs and the health
services is not straightforward, as boundaries have not necessarily been co-terminus and practices and language can be quite different, as are governance arrangements, duties and responsibilities. Evans and Killoran (2000 :136) found that whilst strategies may need to talk about ‘joined up thinking for joined up problems’, there is ‘a difficult reality of securing integrated action on the ground.’ Others add that the historic division between health and social care functions has led to ‘a series of practical barriers to effective joint working which continue to frustrate service users and staff and to consume significant management time’ (Glasby, Dickinson et al. 2010 :245) and Coleman et al (2014) al have also found that there needs to be commitment from all organisations and individuals within health and social care partnerships for effective working.

Given the policy emphasis in recent years, it is natural and easy to assume that partnership working is a ‘good thing’, i.e. that it is beneficial and yields positive results. The evidence is less convincing: a recent systematic review of the impact of organisational partnerships on health outcomes found that ‘there is little evidence of the direct health effects of public health partnerships’ (Smith, Bambara et al. 2009 :218). This view is supported by the work of Evans and Killoran (2000), Dickinson and Sullivan (2013) and Perkins et al (2010). To complicate matters, the concept of ‘partnership’ means different things to different people and organisations, and as such, initiatives can be difficult to evaluate (Glendinning 2002).

HWBs are by their nature inter-organisational and inter-professional. Glendinning (2002) points out that different professional groups will have different approaches, for example in the selection of services considered appropriate to involve for a given outcome. Others list factors they describe as the ‘health and social care divide’(Glasby, Dickinson et al. 2010 :245). The figure below adapts their concept and the medical and social models of Gillespie and Gerhardt (1995) to relate the different approaches and world-views of LG and healthcare and this difference is also noted by Betts who found that health services take an ‘individualistic approach’, whereas, LAs favour ‘collective action’ (Betts 1993 :66). A recent House of Commons report stated that it was hoped the recent PH changes would facilitate a move from a medical model to a social model of health, focusing on prevention (House of Commons Select Committee on Health. Communities and Local Government Committee 2013), so the concepts are important for HWBS.
<table>
<thead>
<tr>
<th><strong>Local Government (social model)</strong></th>
<th><strong>Healthcare (medical model)</strong></th>
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<tbody>
<tr>
<td>state of health is seen as diverse and socially constructed</td>
<td>state of health is seen as a biological fact</td>
</tr>
<tr>
<td>ill health is caused by social factors, identified through ‘beliefs’ and ‘interpretation’</td>
<td>ill health is caused by ‘biological calamities’ and is seen as a deviation from ‘normal’</td>
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<tr>
<td>individual is seen in context- may intervene socially and politically</td>
<td>focus on curing the individual</td>
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<tr>
<td>influenced by social sciences</td>
<td>influenced by science</td>
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<tr>
<td>based on LA boundaries</td>
<td>based on GP registration</td>
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<tr>
<td>accountable to locally elected members</td>
<td>accountable to the Secretary of State</td>
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Figure 6 The medical and social models of health as they relate to local government and NHS healthcare, adapted from the work of Glasby, Dickinson et al. (2010) and Gillespie and Gerhardt (1995).

Interestingly John Ashton, President of the Faculty of Public Health has recently provided an alternative perspective, stating that social care and health are similar in that;

‘social care is overwhelmingly about dealing with challenges once they have arisen. It is akin to the NHS focus on disease rather than the public health focus on prevention’ (Ashton 2013 :29)

The WHO has acknowledged (in relation to disability) that there are limitations in both the social and medical models and proposed the use of the ‘biopsychosocial’ model which combines the personal and environmental factors, as an alternative (2001 :8). Nevertheless, organisations such as the UK Public Health Association have been pushing for PH to move away from the medical model towards the social model (House of Commons Health Committee 2011). Evans and Killoran (2000) found that whilst strategies focus on joint working, it is difficult to achieve in practice; and others add that the historic division between health and social care functions has led to ‘a series of practical barriers to effective joint working which continue to frustrate service users and staff and to consume significant management time’ (Glasby, Dickinson et al. 2010 :245). Angela Mawle, Chief Executive
of the UK Public Health Association, summed up the issue in her evidence to the Health Select Committee:

‘However, the problem arises if there is a cultural difference between the two organisations- local authorities and PCTs. There is a huge cultural difference in terms of training processes, and the kind of member involvement that you get in local authorities you certainly don’t get in PCTs. Therefore the whole opening up of people to looking at new ways of doing things is very hard for them, particularly when the pace of change is so fast’ (House of Commons Health Committee 2011)

Staite and Miller add that in addition to cultural differences, there are also significant differences between professional groups involved on HWBs;

‘The differences form icebergs- some are above the surface, but most lie below, unacknowledged, poorly understood and a hazard to effective partnerships. These include differences in roles, language and experience as well as the differences between those who work within the framework of local democracy and those whose political masters are in Whitehall.’ (Staite and Miller 2011 :8)

These differences have been noted by Directors of Public Health who have recently transferred to LAs from the NHS, some, for example, noting that politics play a significant role in decision-making, and others observing that healthcare colleagues do not grasp the pressures that LAs are operating under and how they work (Vize 2013), however Rayner says that a multidisciplinary approach to PH is needed for success, along with an understanding of political expediency (Rayner 2007).

Since HWBs require LA members and officers, the NHS clinical commissioners and others to work closely together to meet the needs of their populations, partnership working in health will be a policy priority for the foreseeable future. Glendinning (2002 :118) found that ‘local priorities and interests are likely to shape the organisational framework of any partnership, the objectives of the partnership, and the ways in which the partner organisations set out to achieve these objectives. The maturity of relationships and the histories of past encounters will affect the ambitiousness of partnership objectives and associated implementation strategies.’ This observation is important in relation to HWBs
which may be populated by individuals who may well have worked together previously, successfully or otherwise.

Murphy points out that HWBS have built on the foundations of previous initiatives, such as Total Place and Local Area Agreements, which had similar objectives (Murphy 2013) and Glendinning (2002) tells us there has been a great deal of research on the problems associated with partnership working between social care and the NHS. There has not been the same level of empirical research on partnership working for health between the NHS and other LA departments or functions or other health partnerships (Hunter and Perkins 2012). In measuring the success of partnership working, Glendinning (2002) states that different agencies are likely to have different perspectives and Taylor cites Harrison as saying ‘a ‘jointness’ may be better at a strategic level with operational levels playing to their strengths within a joined up framework’ (Taylor 2004:139). It follows that agreement on measuring outcomes and defining the success or otherwise of their initiatives will be necessary for members of the HWBS to establish at an early stage, in order to avoid confusion and conflict.

2.8 The ‘design to doodle’ spectrum
Given the broad themes covered by this research, an overarching conceptual framework offering an understanding of the policy context is required. Harrison is a member of my supervisory team, and at an early stage in my PhD I attended the Teddy Chester Lecture given by him entitled ‘Reorganising the English NHS 1974-2011: from design to doodle?’ (Harrison 2011). The lecture described the different approaches to health policymaking from the major restructure in 1974 until what was then the present day. It built upon earlier work with Wood (1999) describing a change in policy detail from ‘blueprint to bright idea’ and ‘manipulated emergence’. The content of the lecture, whilst available as slides on the University of Manchester website, has not been published elsewhere.

The original ‘manipulated emergence’ concept noted that different administrative approaches had been taken for various health restructures. Starting with the re-organisation in 1974, (which was discussed in chapter 1) Harrison and Wood note that a prolonged period of consultation and planning took place, with extremely detailed guidance given on
the expected structures and functions. They call this approach a ‘blueprint’ and argue that since then;

‘there has been a shift away from the presentation of a blueprint as the intended endpoint of reorganisation, and its replacement by the ‘bright idea’: a rather unspecific vision of how to proceed. Second the role and timing of advice and consultation has changed from a situation where expert advice significantly shaped the content of the blueprint to one in which the expert contribution lay in the translation by incentivised local actors of the bright idea into specific organisational arrangements which accord with the philosophy behind the original idea; we term this ‘manipulated emergence’.’ (Harrison and Wood 1999 :752)

Harrison and Wood (1999) go on to define what a ‘bright idea’ is, defining four elements; the development of policy in secret; providing limited details of the policy; allowing for later policy development; and implementation by incentivised volunteers.

Harrison and Wood (1999) were also clear in their view that the move from blueprint to bright idea cannot be directly linked to party politics; and this is supported by Coaffee and Hedlam commenting on the ‘pragmatic localism’ of New Labour ‘.. it is a radically different sort of politics and policy making process where it appears that the ideology of political ideas has taken a back seat to delivering successful policy on the ground.’ (Coaffee and Headlam 2008 :1589).

It should be noted that in 2004, Greener published a critique of Harrison and Wood’s paper stating that it was descriptive and lacking in theory (Greener 2004). However this criticism was not accepted as valid by the authors as they did not accept the view that everything must be theorised, and in any event this does not diminish the idea as a useful and fitting conceptual framework for the purposes of this thesis.

In his Teddy Chester Lecture in 2011, Harrison built upon his earlier work with Wood and introduced the idea of a spectrum, this time from ‘design to doodle’. He stated that the idea of design includes a blueprint, where the policy has been considered and planned, and is developed to a level of detail. There must also be a coherent link between the policy planning and policy detail. He added that design also includes ‘programme theory’ or a
clear and plausible idea of ‘how the new arrangements will ‘work’ in relation to the deficiencies that they ostensibly address.’ Finally, design recognises and addresses different opinions expressed by those with an interest. The concept of ‘doodle’ describes a situation where the elements of design are not present. At that time, as the figure below shows, Harrison was of the view that the coalition government’s plans consisted of a ‘moderate’ blueprint, and ‘low’ programme theory and consensus seeking (Harrison 2011). However it should be noted that his focus was on the CCG elements of the health restructure rather than on the introduction of HWBs.

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<tr>
<td>Blueprint</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
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<tr>
<td>Programme theory</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Consensus seeking</td>
<td>High - ex ante</td>
<td>Low</td>
<td>High – ex post</td>
<td>High – ex ante &amp; ex post</td>
<td>Low</td>
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*Figure 77 Harrison’s description of different approaches from design to doodle since 1974*

Murphy (2013) helpfully states a public management view of the introduction of HWBs, explaining that there are three explanatory theories available; the ‘public agency or principle agent theories’ which describe a top-down arrangement from politicians to managers, and this includes both local and national politicians. The second category of ‘new public management or public choice theories’ are more flexible and the relationships between politicians and managers are negotiated. The third ‘public value and new public service theory’ emphasises co-production and the role of citizens, with greater
accountability of managers who are required to respond to other demands such as regulation, the political environment and occupational standards (Murphy 2013:250).

It appears to me that the development described by the three public management theories are compatible with Harrison’s spectrum in that they both describe a shift from a top-down or ‘design’ approach, via a more complex and nuanced approach, where the design is less detailed and specific, and finally to a ‘doodle’ situation where there is an absence of central or top-down specification and policy is made at a more local level where changes are made in response to local drivers and factors.

The ‘Design to Doodle’ conceptual framework and the work of Murphy are discussed further in relation to the research findings in chapter 11.
Chapter summary

I have described a broad literature, setting the background to this research, which covers recent legislative changes and the policy, political, financial and structural contexts in which the research took place. These are complex and linked to historical policies, relationships and decision-making going back to at least 1974, if not before. I have also introduced Harrison’s ‘Design to Doodle’ conceptual framework which is used to provide an understanding of the research findings. For reasons of space, consideration of each area has necessarily been limited, however my intention has been to set the scene for the research questions and design discussed in the following chapter, and provide a sense of perspective from which to understand the research findings and discussion.
3 Research design and methods

This chapter sets out the research questions developed from the literature review, and the rationale and application of the methods I used to address them. The role and impact of my EH background at different stages of the project is discussed in detail in chapter 11 and so has been largely omitted from this chapter to avoid duplication.

3.1 Aims

The overarching aim of the research project was to explore the approaches to tackling health inequalities taken by Health and Wellbeing Boards (HWBs) and associated organisations as they were established; during their operation in ‘pre-shadow’ and ‘shadow’ forms; and as they went live in April 2013, with fieldwork extending from December 2011 for 18 months. Within this, there was a focus on the role of environmental health (EH), a local government PH occupation. Addressing both aims also required consideration of how HWBs and associated organisations were developing locally.

3.2 Research questions

Taking into account both the findings of the literature review and the overall aims of the project, the following overarching and subsidiary research questions were developed. The three overarching research questions are numbered and in bold, with the first being the primary thesis question (Andrews 2003). The questions were designed to allow an exploration of three key issues (HWB development, health inequalities and environmental health) during HWB establishment and development over a period of around 18 months.

The subsidiary questions (marked with a bullet) were derived from the overarching research questions and contributed towards answering these (Andrews 2003), guiding data collection. Contributory questions, which need to be answered to address the subsidiary and ultimately the overarching questions follow the bullets (Andrews 2003). Mason (2002) similarly differentiates research questions as ‘big’ or ‘mini’ and this approach of identifying different levels of questions lent clarity to the research at the planning stage.

1. How will HWBs develop locally and what underlying issues can be identified?
This overarching question developed from the literature where it was indicated that a policy of localism was likely to result in local variation. The literature also presented a mixed picture on the role of structures, as whilst there were concerns that district councils in two-tier areas might be overlooked, some literature indicated that structures may not be the most important factor in effective partnership working. The following subsidiary questions relate to this first overarching question;

**HWB constitution and composition**

- How will the HWBs develop and function?

What is the decision making process? What is the composition of the HWB? What are the structures and sub-structures? What is the level of attendance and participation?

**Local conditions and context**

- Will the local context affect the operation and decision-making of the HWB?

Does the HWB cover unitary or 2-tier LA areas? Are boundaries of different organisations, including Clinical Commissioning Groups (CCGs), co-terminus? What are the arrangements for communication between organisations and individuals? Is the historical context relevant?

The related second question derived from the literature which revealed that the theories relating to the causes of health inequalities; the social determinants of health; and how they should be addressed are by no means universally agreed. The literature also indicated that many of the social determinants of health would be outside the core sphere of influence of HWBs and it was unclear whether this would be acknowledged or recognised by participants. In particular, it was unclear how HWBs would respond locally to the wider economic and political contexts, particularly with the enhanced role of elected members in health decision-making. There is also little evidence that health partnerships have delivered
improvements in health outcomes during previous initiatives and this question is important in the light of the new structural arrangements.

2. **Do HWBs tackle health inequalities and does this vary between areas?**

   **Health inequalities**
   - Which approaches/theories of health inequalities will the HWBs adopt?

   What is the justification for this? Do they subscribe to the lifecourse approach? Will the social determinants of health be tackled?

   **Action planning**
   - How will HWBs approach the task of tackling health inequalities?

   Does the action link to the approaches/theory? How will success be measured?

The final question arose from the literature in that EH does not have a statutory role on HWBs and in two-tier areas is based at the district council level, in a different organisation from the HWB. In addition, the history and development of PH indicated that PH might be broadening to include recognition of the role of the environment in health (at least at the international level), and also the role of LG in historic PH improvements.

3. **Is environmental health recognised as having a role in tackling health inequalities and how does this play out locally?**

   **Environmental health**
   - What is the role (if any) of environmental health?
Are environmental health practitioners or managers represented on HWBs? What is their level of involvement? What are the reasons for involvement or non-involvement?

3.3 Qualitative approach
As the area of research was unclear and developing (Morse 1991) and because it was hoped that factors influencing the development and decisions of HWBs would be understood, I used qualitative research methods to address my exploratory research questions. Yin (2009:8) states that case studies are particularly appropriate when answering ‘how’ and ‘why’ questions, when there is no requirement to control behavioural events and where there is a focus on contemporary events, as in this research. I chose to use multiple longitudinal case studies utilising observation, interviews and documentary analysis. I also carried out contextual interviews from outside the case study sites and these are discussed in further detail below.

3.4 Design summary
The research was initially conceived with a narrow focus exploring how the newly developing LA Health and Wellbeing Boards (HWBs) were tackling health inequalities. During the project planning stage, it became evident that the role of EH should be included within the research. This was because the PH system changes were likely to have an impact; that this was of interest to me; that I would be able to use my practitioner background to enrich the project; and to take the opportunity to look at an under-researched area in some depth. The project developed into two inter-related strands. The first strand involved the four case study sites and the second involved interviewing EH practitioners and managers at each of these case study sites. Including EH as a central part of the project also enabled me to use more fully the knowledge, experience and network connections that I had built up as a practitioner.

Reed and Procter (1995:10) describe this role of a practitioner researching other practitioners as a ‘hybrid’ role, sitting on a continuum between ‘outsider’ and ‘insider’ roles. Using a two-strand project design enabled me to compare this role with that of the HWB strand of the project, where my position was more that of an ‘outsider’, albeit one with a good working knowledge of the English LA system.
The research design is summarised in the figure overleaf, which shows both inductive and deductive approaches to answer the research question using qualitative methods.
Figure 8 The research design and inductive and deductive themes

The research design and inductive and deductive themes

- conception of health inequalities and role of social determinants
- conception of how best to tackle health inequalities
- composition and constitution of the HWB
- political context and influence
- historical context
- structures and administrative arrangements
- themes arising during data analysis
- role of EH
- approach of HWBs in tackling health inequalities

Methods:
- interviews
- observation
- document analysis

Description and conceptualisation of findings
3.5 Longitudinal case studies

Each of the four chosen HWB sites was identified as one case study. In defining what a case study would be, the views of Mason were useful; she says that ‘these may be organised around and draw upon a range of data sources,’ and goes on to say that they may include ‘people, organisations, settings... and events’ among other factors (2002 :166). With reference to Mason, each case study primarily focussed on a HWB, as an ‘organisation’, however HWBs can also be understood as a ‘setting’ and in many ways is an ‘event’, being the implementation of new legislation and policy. In addition, I included associated LAs and their professional groupings, CCGs and PCT clusters as ancillary ‘organisations’ and other relevant individuals as ‘people’.

Gerring (2004 :349 & 341) defines a case study as ‘an intensive study of a single unit for the purpose of understanding a larger class of (similar) units’ (the issue of generalisation is discussed further below). He goes on to say that ‘case studies enjoy a natural advantage in research of an exploratory nature’ as was the case in this project. Yin (2009 :4) agrees that this approach is especially useful for understanding ‘complex social phenomena... [and] allows investigators to retain the holistic and meaningful characteristics of real-life events’. Mason adds that reasons for using this approach include where ‘this method of data organisation will provide the most appropriate form of analytical ‘handle’ on your data, enable you to make comparisons and build explanations in a distinctive way’ (Mason 2002 :166). Having considered the alternative possible methods identified by Yin as appropriate to social science research, namely ‘experiments, surveys, histories, and economic and epidemiologic research’ (2009 :2), I came to the view that a case study approach would be the most appropriate to enable me to research HWBs during the development stage, both at a deep level and allowing the flexibility to respond to and explore the changing situations at each site over a period of time.

Hammersley and Gomm (2000 :5) suggest that design of a case study will depend upon its purpose and is ‘likely to be more detailed and open-ended in character.... where the concern is with describing and / or explaining what is going on in a particular situation for its own sake’ and accordingly a detailed and open-ended approach was effectively used in this...
research. The use of rich and detailed data to achieve a ‘thick description’ is discussed in more detail below.

Several factors were considered when deciding to use multiple case studies rather than to focus on one. In-depth case studies are intensive and time-consuming, and as a lone researcher the decision to include multiple sites was not taken lightly. Yin describes types of multiple sites case study approaches; literal replication where like results are expected; and theoretical replication where varied results are expected. To answer the research questions, it was clear that more than one case study site was needed, in particular to explore whether constitutional and structural matters (particularly in contrasting unitary and two-tier authorities) and other local conditions, such as local politics, history and the role of other organisations had an impact on the approaches of the HWBs to tackling health inequalities and the role of EH. Given that a variety of sites were included, this research used Yin’s idea of theoretical replication, whilst maintaining the same methods at each site. Based on a similar, but larger scale, research project (looking at the introduction of health scrutiny) four case study sites were chosen to allow sufficiently in-depth data gathering and analysis within the resources available (Coleman 2006).

The case study research was longitudinal as data gathering took place over some 18 months, rather than as a one-off ‘snapshot’. Lewis (2007) says that longitudinal research is appropriate for looking at how a service or policy is implemented over time, and was therefore ideal for exploring the development of HWBs. She notes that there are four key domains of change: individual, service, policy and structural; this research project covers all four elements in some depth and they are reflected in the research questions. Pettigrew, Woodman et al (2001) consider that an appreciation of context is also vital when researching organisational change which links with the policy and structural elements identified by Lewis. All four case study sites were studied in-depth and simultaneously which enabled the maximum data to be collected whilst adhering to my project timetable.

### 3.6 Contextual sites
Recruitment and access to research sites is well-established as being a challenging element of empirical research projects (Mulhull 2002). On several occasions, individuals contacted via my network, who were keen for their authorities to be one of the main case study sites,
were not supported by other people associated with the HWB. It became apparent that there were a number of EH practitioners who were willing to be interviewed, but who could not participate as part of a case study site. In order not to lose this valuable source of context data, I successfully applied for an extension to my university ethics approval to interview individuals outside the case study sites.

### 3.7 Sampling

As described above, the case study sites were theoretically or purposively selected for maximum variation (Patton 1990) to cover a range of geographical areas (urban and rural), LA complexity (unitary and 2-tier) and political composition. Cresswell (2003) lists Miles and Huberman’s factors to be taken into account when choosing research participants and their locations. These are: setting, actors, events and process. Applying these aspects to the project, the setting was the geographical locations of the HWBs (in the Midlands and North of England); the actors were the HWB members, support officers and their collective decision making as the HWB (Chair and other key members); the events were the discussions around the JSNA and JHWBS (including tackling health inequalities) and any further changes to policy and legislation; and the process was the development of this strategy.

In addition to the case study sites, the EH practitioners and managers interviewed from the other context sites, were similarly purposively sampled from all the English regions, to include a mix of urban and rural, and unitary and two-tier areas.

The sampling strategy allowed me to gain insights into the varied social determinants of health at play in urban and rural locations and how these were reflected in the JSNA and in the accompanying prioritising strategy, the JHWBS, produced by the HWBs. It is worth noting again here that unitary authorities are located predominately in urban areas and that the level of LA complexity has influenced the HWB composition.

Although the research at each site was undertaken at simultaneously, the nature of the legislative and policy landscape led to my looking at HWBs at different stages of development for much of the data collection phase. Whilst all upper-tier LAs were required to have a ‘live’ HWB in place by April 2013 the rate of development between the different
case study sites and those described by the contextual EH interviewees varied considerably. It was initially proposed that I would compare an ‘early implementer’ site with a site outside this scheme, however almost all LAs put themselves forward as ‘early implementers’ so this plan proved unworkable.

3.8 Recruitment

The identification of case study sites for the project was relatively simple, as information on HWBs was readily available, being linked to upper-tier LAs (Department of Health 2011) and a number of potential case study sites were approached for participation. The geographical areas chosen were selected to maximize existing links with LAs, in addition to being reasonably accessible from where the researcher lives (Birmingham) and studies (Manchester).

Once identified as potential case study sites, the chairs or support officers of the selected HWBs were approached either directly or via a known contact from my network (and in one case also by my supervisor) and provided with details of the study, along with a request for participation. The aims of the research were made clear by the provision of an information sheet which was given to participants, via the chair or relevant support officer. This information sheet is attached as appendix 1.

EH is a relatively small (when compared to medicine) graduate PH occupation, with few accredited courses. Membership of the CIEH is not obligatory. However it has an established system of regional and special interest groups, and LAs have county-level liaison groups, where issues of a technical nature are discussed. The CIEH produces a monthly magazine, electronic newsletters and has recently re-launched its bi-annual peer-reviewed journal (The Journal of Environmental Health Research). All of the above contribute to a occupation whose members often have recurring connections or links throughout their working lives or who are at least fairly familiar with the activities of their more outspoken peers. I refer to these connections as a ‘network’. Unfortunately, but predictably, gaining access to the developing HWBs and the individuals sitting on them was one of the most challenging elements of the research (Morse 1991); (Mulhull 2002) and my network unexpectedly played a significant role in recruitment. However, this was not detrimental and recruitment was achieved across the sampling criteria.
The figure below lists the recruitment method for each of the EH practitioners and managers interviewed for the project, including those connected to the four case study sites. It can be seen that all interviewees were recruited via networks within EH.

<table>
<thead>
<tr>
<th>Method of Recruitment</th>
<th>No. of Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Part of my own network</td>
<td>8</td>
</tr>
<tr>
<td>2. Via a member of my own network</td>
<td>4</td>
</tr>
<tr>
<td>3. Introduction by a mutual contact at the CIEH</td>
<td>4</td>
</tr>
<tr>
<td>4. Via an introduction to a colleague of a colleague by a mutual contact at the CIEH</td>
<td>1</td>
</tr>
<tr>
<td>5. Met at an EH conference in the early stages of my project</td>
<td>1</td>
</tr>
<tr>
<td>6. Via contact made following an article about my project in ‘Environmental Health News’</td>
<td>3</td>
</tr>
</tbody>
</table>

*Figure 9 The number of EH interviewees by method of recruitment*

It is possible that the use of my network for recruitment could have introduced bias, in that the individuals with whom I had developed relationships were likely to have a similar outlook and interests as myself. Care was taken to recognise and where possible to mitigate this risk. However in any non-randomised sampling strategy the potential for bias exists.

Using the CIEH as a recruitment tool was arguably the most risky strategy for potential bias, as many EH practitioners and managers are not members, and those recognised by the institute at a national level were perhaps those positively disposed towards the organisation and its role or at least had an interest in actively supporting the profession. Contacts made via the CIEH tended to be with higher-profile and more senior individuals than those in my own network. It was notable that the interviewees recruited via the CIEH generally had a clear agenda of their own and were often powerful actors in their own localities. This CIEH recruitment role was not actively sought and did not form part of the project plan, but evolved naturally from the supportive stance of certain officers. The quotation below sums
up quite neatly the problems experienced in reaching high-level interviewees as a PhD student, and the role of occupational networks in overcoming them;

‘...you won’t get it in the door I don’t think. I’ll help you if I can, when you’re ready.’ (EH practitioner in national-level post ID33)

To attempt to counter any bias, a standard interview schedule was used (see appendices 3 and 4) and efforts were made to reach a variety of people working in a range of authorities, both unitary and two-tier, across all the English regions. Additionally, not all introductions resulted in an interview, particularly where these were from geographical areas already sampled.

A further notable factor in using my network to recruit was the fact that many of my peers were at a similar career-stage to myself and were holding middle-management posts in LAs. These individuals were able to access heads of service and set-up interviews that perhaps would have been more challenging to arrange if they had been newly-qualified and less well established.

The use of occupational networks as a means of recruitment has been little discussed in the literature, and most health research recruitment commentaries relate to general practitioners (GPs). A German study of GPs found that physician network-based recruitment increased participation rates for a questionnaire study, but that this could lead to sampling effects (Wetzel, Himmel et al. 2005) and a literature review of the recruitment of physicians in research also found that the use of personal and friendship networks increased recruitment rates (Asch, Connor et al. 2000). Although my research methods were very different and relate to occupational rather than personal networks, my experience supports the findings of both studies; on balance, given the difficulty of recruitment for research projects, the overall benefits of using occupational networks in EH research outweigh the risks of bias involved, provided that measures are taken to acknowledge and, where possible, to counter those risks.

Eventually, four HWBs agreed to take part in the research and data collection started in late 2011.
3.9 Site summaries
Between the case study and contextual sites, the research included semi-structured interviews with people from all the English regions and that a variety of unitary and two-tier systems were included, as were rural and urban, and affluent and deprived areas. In total, 19 sites (4 case study and 15 contextual) were included; however 2 of these do not correspond to distinct geographical areas.

There were 4 case study sites included in the research; 2 were unitary authorities and 2 were two-tier, in accordance with the sampling strategy discussed in chapter 2. The figure below uses observational data to provide a description of each site.

<table>
<thead>
<tr>
<th>Case study site number</th>
<th>Description</th>
<th>Unitary/Upper-tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Midlands, suburban and rural areas, affluent with North/South split in areas of deprivation. The population is both growing (rising birth rate) and ageing, and 90% describe themselves as ‘white British’. There are concerns around dementia, hospice provision, and carers. Unemployment levels are falling, although youth unemployment remains an issue. Bi-monthly HWB meetings, usually in the council chamber located centrally in the county town. Meetings tightly chaired during the shadow stage, but discussion encouraged. Independent chair during the shadow stage, switching to elected member on going live. There were many changes to the HWB membership during the research. There were 2 CCGs, one overlapping with a neighbouring LA. Conservative dominated.</td>
<td>Upper-tier</td>
</tr>
<tr>
<td>2</td>
<td>Midlands, suburban and rural areas surrounding a major multicultural city, primarily affluent but with pockets of deprivation. There is a growing and ageing population and the number of people below pension age is lower than the UK average. 90% describe themselves as ‘white British’. Seen nationally as a HWB leader. Quarterly meetings were held in a council chamber in offices on the edge of town. Meetings were tightly chaired with limited discussion in public. Chair is elected member. Minimal changes to membership during the research. There were 2 CCGs. Conservative</td>
<td>Upper-tier</td>
</tr>
</tbody>
</table>
Midlands, urban with significant areas of deprivation and a ‘young’ population (almost half are under 30) which is very ethnically diverse with 90% of people in some wards describing themselves as other than ‘white British.’ Suburbs are generally affluent and inner city population density is high. Air quality is often poor and there are concerns about obesity, particularly in children. HWB meetings are held in the centrally located council offices. Major changes to the membership, meeting frequencies and political make-up occurred during the research. Meetings were very tightly chaired. Chair is an elected member. There were 3 CCGs including overlaps with other LAs. Labour dominated from May 2012, but opposition members on HWB.

North West, urban and suburban with significant areas of deprivation. The population is ageing and almost 97% describe themselves as ‘white British’. Life expectancy is lower than the national average. Smoking, drinking and substance misuse are concerns. Meetings held in centrally located council chamber and were loosely chaired with frank discussion and consensus decision-making encouraged. Chair is elected member. Few changes to HWB membership during the research, but meeting frequencies declined. There was 1 CCG, following a merger at the insistence of the LA. Labour dominated.

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**Figure 10 Case study site numbers and descriptions**

The contextual sites focussed on environmental health services and a range of unitary, district and borough councils were selected for inclusion. The figure below shows the site numbers, provides a short description of the area, the political leadership and the structure.
<table>
<thead>
<tr>
<th>Site</th>
<th>Description</th>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Mainly rural area, with pockets of deprivation and affluence (North West)</td>
<td>District council</td>
</tr>
<tr>
<td>9</td>
<td>Mixed urban and suburban area (South Central)</td>
<td>Borough council</td>
</tr>
<tr>
<td>10</td>
<td>Mainly rural area, with pockets of deprivation and affluence (South West)</td>
<td>District council</td>
</tr>
<tr>
<td>11</td>
<td>Mainly urban and suburban with several areas of deprivation (North East)</td>
<td>Unitary</td>
</tr>
<tr>
<td>12</td>
<td>Mainly urban and suburban, very affluent area (South East)</td>
<td>Borough council</td>
</tr>
<tr>
<td>13</td>
<td>EH academic</td>
<td>N/A</td>
</tr>
<tr>
<td>14</td>
<td>Mainly urban and suburban with several areas of deprivation (North West)</td>
<td>Unitary</td>
</tr>
<tr>
<td>15</td>
<td>Mainly rural area, with pockets of deprivation and affluence (East of England)</td>
<td>District council</td>
</tr>
<tr>
<td>16</td>
<td>Mainly urban and suburban with several areas of deprivation (South West)</td>
<td>Unitary</td>
</tr>
<tr>
<td>17</td>
<td>Mainly urban and suburban with several areas of deprivation (Yorkshire and Humber)</td>
<td>Unitary</td>
</tr>
<tr>
<td>18</td>
<td>Mixed rural and suburban area, with pockets of significant deprivation (South East)</td>
<td>District council</td>
</tr>
<tr>
<td>19</td>
<td>Urban, very affluent (London)</td>
<td>Unitary</td>
</tr>
</tbody>
</table>

Figure 11 Contextual site numbers and descriptions.

3.10 Data collection

As described above, semi-structured interviews, observation and document analysis were used to collect data and these are discussed in further detail below.

3.10.1 Interviews

In addition to the longitudinal case studies, to gain additional national (English) context, and in response to offers from various EHPs and managers during the recruitment stage, EH practitioners and managers were interviewed in each English region, in addition to two EH practitioners working in academia and national policy. A total of eighteen people took part in these semi-structured interviews from a variety of LA, which included a mix of unitary and two-tier authorities and a mix of local political leadership.
The primary means of data collection was semi-structured interviews with individuals involved in setting up and managing the HWBs; HWB members; and with EH practitioners and managers. The interviews had a loose structure to ensure that important areas were covered, whilst being flexible enough to accommodate individual variations and explore new issues (Britten, Jones et al. 1995). This enabled an appreciation to be reached of what people understood as health inequalities and how they thought these might be addressed; and whether these responses differed based on occupational or political backgrounds or other factors; and how any differences were resolved.

Prior to each interview commencing, interviewees were provided with an information sheet and asked to complete a consent form. Both documents are attached in the appendices as 1 and 2 respectively.

The semi-structured or focussed interviews each began with my asking the interviewee to describe their work background, their current role and how this fitted with the HWB. Key areas of interest were then discussed including the membership and development of the HWB, views on health inequalities and the role of EH locally. At the end of the interview, each interviewee was given the opportunity to add any further information that they wished. Several interviewees sent me documents relating to their local HWBs following our meeting. The interview schedule for HWB members and support officers is attached as appendix 3 and the schedule for EHPs and managers is attached as appendix 4.

The areas of focus listed in the schedule were refined as the project progressed and my knowledge increased, and also in relation to the position and interests of interviewees, for example EH managers were often unfamiliar with HWB constitutional matters and HWB members typically knew very little about EH. Given the diverse positions of the interviewees it was not appropriate to ask every question to every interviewee; conversely, discussion of some topics led to follow-up questions being asked (Rubin and Rubin 1995), generating very rich data on specific topics from some interviewees, for example on morale in EH. With the exception of CCG representatives who were extremely challenging to recruit and who I was not permitted to interview at one site, interviews were continued until no new data was found; this is ‘sampling to saturation’ as described by Green and Thorogood (2009) or ‘theoretical saturation’ described by Strauss and Corbin (1998).
All interviews were carried out in person, with the exception of one, which was initially carried out by telephone and followed up with an interview in person at a later stage in the project. The majority of interviews were carried out at the place of work of the interviewee, or at the site of HWB meetings, typically council offices or committee rooms. Some interviewees requested to meet outside their place of work and three interviews were carried out in local cafes (chosen by the interviewees), and one was held in the interviewee’s home. Whilst the cafe interviews perhaps provided for more candid responses, they were more difficult to accurately transcribe, as the background noise was at times significant. Interviews generally lasted for between 40-80 minutes, depending on the availability and conciseness of interviewees. A total of fifty interviews were carried out, although one person was interviewed twice (as described above) and two interviews involved multiple (2) respondents. Interviewees were selected by a variety of means, at the case study sites this was primarily by discussion with support officers (who often assisted with recruitment) and by identification of key individuals during observation of HWB meetings. Of these, 31 interviewees were from case study sites and the remainder were from contextual sites. There was a small amount of snowball sampling (i.e sampling via referral) at case study sites, however this was more evident in sampling via my network.

Interviews in person were digitally recorded (audio only) and all HWB and interviewee data was anonymised by interviewee numbers generated by Atlas ti. and generic role descriptions.

Whilst I transcribed the initial interviews, both to experience the process and immerse myself in the early data, the majority were professionally transcribed and later checked by myself for accuracy. This initial transcription was very useful in the development of my early awareness of new themes; however the time taken to transcribe all the interviews myself would have severely restricted the volume of data I could have collected.

As I have described, the primary method of data collection for the EH strand of the project was semi-structured interviews. It was clear that the use of my occupational network as a recruitment tool had an effect on the dynamics of many of the interviews carried out compared to interviews with people from non-EH backgrounds for the other strand of the
project. My background also influenced the schedule of interview questions used (Hand 2003).

Using my occupational network inevitably resulted in all the EH interviewees being aware of my practitioner background. On one occasion, an interviewee showed a copy of an article I had published in the CIEH magazine on early findings of the project and suggestions for EHPs on how they might make the most of opportunities in the new system (Dhesi 2012) and was keen to talk about it for the benefit of a student who was present.

It appears that there are two significant consequences of sharing an occupational background, identity and connections on the quality of data gathered. The first is a greater level of intimacy and trust, with interviewees being noticeably more candid and forthcoming when compared to interviewees who did not share my EH background.

On arrival at interviews, where there was a common link between myself and the interviewee, this provided an easy point of initial interaction. Questions as simple as ‘have you seen x lately?’, ‘do you know x?’ or realising that we both went to the same university served to break the ice and create a relaxed and informal atmosphere, promoting a feeling of trust and confidence between both parties. To illustrate, on arrival at an interview, I was introduced by an interviewee to their colleague with the comment;

‘The good news is, she’s one of us’ (EH manager ID43, site 14)

They went on to explain that they had been interviewed for other projects by non-EH researchers and had at times struggled to communicate a detailed understanding of the context in which they were working. Our shared backgrounds resulted in a level of honesty and increased depth of data, which perhaps it would not have been possible to gather in the time available without such commonality.

An example of the value of a shared experience within EH, would be the comments made by a member of my network who was aware that I had previously worked in rural areas;

‘You worked in a rural area, so you know...’
'They assume it’s all lovely and everyone’s rich and running around in Range Rovers but actually, as we know, that’s not the case.' (Emphasis added in bold) (EH manager ID44, site 15)

Chew-Graham et al (2002:287-288) found in a study of GPs, that where interviewers and interviewees had a shared occupational background, responses were often more ‘emotionally charged’, generating ‘rich and intuitive responses’. This is supported by the following comment from another interviewee from my own network;

‘The thing is I think the profession at the moment is feeling quite, oh God, you know, quite downtrodden really, it doesn’t help that the government is going ‘regulation is crap, we hate regulators’ and all this kind of stuff, erm all the cuts, FSA going ‘oh we’re going to have you...’ (Emphasis added in bold) (EH manager ID1, site 3)

Such candid and emotionally honest comments were not so forthcoming from interviewees with non-shared backgrounds. A further phenomena of shared backgrounds described by Chew-Graham et al (2002) is the expression of vulnerability, as seen in the following tongue-in-cheek comment from a well-respected EH manager;

(whispers): ‘I was never very good at food – never very good at anything in Environmental Health actually, but food, I was terrible’ (EH manager ID40, site 11)

The second consequence is that I, as the interviewer, had a greater understanding of the nuances in interviewee responses, their language, and the environments in which interviewees were working, which meant that I was more sensitive to what was being said and able to probe more deeply than with respondents whose backgrounds I was less familiar with, such as GPs. In contrast to my experience, others have suggested that this shared understanding could result in issues of interest being unchallenged (Chew-Graham, May et al. 2002).

A further significant factor is the influence I inadvertently exercised on interviewees with a limited knowledge of EH. Part of my interview schedule included a question on what the
interviewee understood of EH. Many respondents knew little about the role, but were keen to learn more. I was able to answer their questions in perhaps greater detail and with more practical examples than interviewers with other backgrounds may have done. The impact of this was reflected in the comment of one interviewee, who was a member of a case study HWB;

SD: ‘..that was all my questions, the idea wasn’t to influence you!’

Interviewee: ‘No, but, I think, you have, positively, I’m just…I shall think about the best way I can suggest something’ (HWB member ID20, site 1)

A further example of inadvertent influence, is the following comment of a HWB member following interview questions around the role of EH in the new system at a different case study site;

‘It’s not really been highlighted, apart from my conversation now with you really and, I think, I would like to understand that further’ (HWB member ID5, site 3)

I was also asked by more than one EH manager at the end of an interview, what action I thought they should take to play a fuller role in the new system. On one occasion, I suggested that the individual attend a HWB meeting at site 1, to gain a better understanding of how their service might fit into the agenda. The manager attended the following HWB meeting as an observer and as a result was asked to contribute a paper on what their service could offer for the board to consider.

These influences were not planned and there was never any intention to manipulate any of the sites or individuals studied. Nevertheless, it is evident that my background had an impact on the business of at least one case study site in the project.

3.10.2 Participant role descriptions
For simplicity and to preserve anonymity I have used generic role descriptions throughout this document. These are as follows:

- ‘Health and Wellbeing Board member’ describes both statutory and non-statutory HWB members with voting rights.
• ‘Health and Wellbeing Board support officer’ describes a person employed in a HWB support role who is not a voting member of the HWB.

• ‘Environmental health manager’ describes a person with responsibility for the management of the EH service. This also includes people with higher management responsibilities, such as directors and members of LA senior management teams. One environmental health manager was in a chief executive role. The majority of environmental health managers came from an EH background, however one had a trading standards and management background.

• ‘Environmental health practitioner’ describes a person who was fully qualified as an environmental health practitioner and holding a LA post involving enforcement and regulation.

• Two other interviewees held specific roles, one was an EHP and academic in an English university and the other is an EHP with a national policy role. Neither of these posts were connected to LA sites, however the inclusion of these interviewees provided valuable additional perspectives.

3.10.3 Observation

The observations of meetings relating to the setting up of HWBs and their subsequent work were non-participatory and involved my taking contemporaneous fieldnotes. Mulhull (2002) reminds us of the importance of using visual observations and noting environmental factors, not merely recording what is said and Mason (2002 :98-99) adds that the decisions on fieldnotes to take ‘will partly reflect, partly constitute, their [the researcher’s] methodological and theoretical orientation’.

In total, 23 HWB meetings were observed, totalling approximately 55 hours, across the four case study sites using the ‘non-participant as observer’ strategy described by Gold (1958) in order to maximise the opportunity of observing ‘natural’ behaviour. Observation was overt and HWB members were advised of my role, in some cases via the chair and in some cases via the support officers at each site. Some sites met in public during the shadow stages and
others did not, and in general I sat in the public areas or at the rear of the room. At one site, I was asked to sit at the table with the other HWB members and to introduce myself directly to members at the first meeting. Once the sites went ‘live’ all were required to meet in public and from this point on I sat with the public observers during meetings at all sites.

3.10.4 Document analysis

Document collection was straightforward and was primarily achieved by requesting to be added to mailing lists for HWB correspondence, in addition to collecting copies of key documents at meetings and from individuals. Many HWBs had websites with links to documents, such as agendas and minutes. This enabled me to collect a range of documents including terms of reference, minutes of meetings and the JSNA and JHWBS at different stages of drafting. I was able to collect a range of both published (in the public domain) and unpublished documents.

The focus was on gathering documents relating to the setting up and development of HWBs and their approaches to tackling health inequalities, along with the role (if any) of environmental health. Duffy (1999) describes two possible approaches to the use of documents; source orientated and problem orientated. The research combines both approaches, as although the source material to some extent influenced the project direction, a limited problem orientated approach was also necessary to ensure that the key research questions were addressed.

3.11 Data organisation and analysis

A large amount of documentary (and other) information was collected and due to time constraints, key documents were selected (Duffy 1999). Efforts were made to ensure that a balanced selection, relevant to the research question were chosen, including mainly terms of reference and various drafts of JSNAs and JHWBSs. Duffy (1999) also indicates that when analysing documents, attention should be given to the purpose for which a document has been produced and the characteristics of its author. This includes an awareness of any author motives or other reason for inaccuracy, when making judgements of reliability.

The 3 types of qualitative data collected required detailed analysis and comparison. Interview transcripts, observational notes and other collected data were thematically
analysed using a combination of approaches, both inductive and deductive which are relevant to qualitative research (Murphy, Dingwall et al. 1998). This process is described by Miles and Huberman (1984) who note the usefulness of establishing some codes before collecting data whilst also acknowledging that these will change, be refined, dropped or sub-coded as data is analysed. The deductive method developed by Richie and Spencer (1994) was a useful starting point for data analysis. This approach, they say, ‘involves making sure that the original research questions are being fully addressed’ (1994:181).

The deductive approach described above was combined with an inductive approach, based on that described by Strauss and Corbin (1998) where ‘open coding’ is used to identify concepts arising from analysis of the data. This approach was used to identify the ‘unknown factors’ at the research planning stage and allowed deeper analysis, with new categories established during analysis of the data (Pope, Ziebland et al. 2000). Hsieh and Shannon (2005) describe conventional content analysis as that which arises from the data and that this analysis is appropriate where a phenomenon about which little is known is to be described, making its use appropriate for this study.

Analysis involved detailed coding according to concepts and themes; this began at a general level and eventually led to the identification of ‘theoretical or policy implications’. I began with the identification of most of the main codes, which I then refined and added to as more detailed analysis was carried out (Rubin and Rubin 1995). Barbour (2003) reinforces this approach of finding the origin of codes in data, reminding us that codes need much revision and development. Rubin and Rubin (1995) add that it is important to identify linked and connected or opposite themes during data analysis and also to note where themes can be put together to make a story or to identify overarching themes. The final code list was tested with the wider team and is attached as appendix 5.

Some data analysis took place during data collection and throughout the project as recommended by Coffey and Atkinson (1996) and Miles and Huberman (1984). Aside from being good practice, this was a necessity as document collection continued until June 2013. Rubin and Rubin (1995) agree that data analysis should be an ongoing process whilst data collection is carried out, allowing questions to be refined to explore new issues and themes during subsequent interviews. They also say that this results in two attempts at data
analysis: the first during collection, and the second more detailed, formal analysis which takes place after information is collected. This analysis of data whilst collection is ongoing also enabled ‘deviant’ cases and new themes to be explored (Pope, Ziebland et al. 2000). This is known as ‘constant comparison’ analysis. I used the computer programme Atlas.ti. to assist coding and organising the different types of data collected.

In developing my coding system for analysing data, I am conscious that the codes used in relation to EH are perhaps more detailed than someone without an in-depth knowledge of the role would use. Others have noted that qualitative data analysis does not use ‘neutral techniques’, as these are influenced by the backgrounds and perspectives of those who have produced them (Mauthner and Doucet 2003 :415). Background and experience have previously been described as factors which can influence how data is used; with ‘inside knowledge’ as a useful additional data source. However, background knowledge may also include assumptions that could cause bias (Holloway and Biley 2011 ) and may lead to a failure to probe areas that ‘seem self-evident’ (Hand 2003 :22). Whilst background knowledge may be beneficial in identifying more nuanced themes, there were also elements that someone with a less personal involvement could identify more readily and my non-EH supervisory team have helped to redress this balance.

3.12 Data interpretation

Following the analysis of data, the findings were interpreted with reference to the existing literature (Rubin and Rubin 1995). Glendinning (2002) tells us that care needs to be taken with evaluating the successes of partnerships formed between members who were collaborating before the initiative began. It was important, therefore, to establish the historical context in which each case study site operates.

My supervisory team are extremely experienced qualitative researchers, with a combination of policy, health service and LG backgrounds. Regular supervision meetings during the data collection and analysis periods enabled me to discuss and test my findings at an early stage. It also very helpfully gave an opportunity for different perspectives and interpretations of other researchers to be considered and discussed, although the final decisions were mine. In addition, by working closely with a colleague undertaking a related PhD research project (Warwick-Giles forthcoming) looking at how CCGs were tackling
health inequalities, I was able to understand my early findings in the wider health service context.

Throughout the data collection and analysis stages, I was encouraged to share my findings with my EH peers and this required me to make the jump from descriptive analysis to policy and practical implications at an early stage. It also enabled me to test my findings in a wider arena and to receive feedback from those in the field whom I did not have the capacity to formally interview. This added depth to my understanding at an earlier stage than may have been otherwise possible. These issues are discussed in greater depth in chapter 11.

3.13 Validity
The project was designed to ensure validity and reliability and an audit trail was maintained throughout. By using multiple case studies, and within these using different methods, I have built-in a level of validity, providing ‘a major strength, insofar as it enhances the completeness of the data’ (Murphy, Dingwall et al. 1998 :11). Yin supports this view, adding that ‘the evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust’ (2009 :53).

The triangulation achieved by using different methods is described by Bell (1999 :103) who quotes Cohen and Manion (1994) when she describes this approach as ‘space triangulation’ as opposed to ‘time triangulation’ which would take place over several years. Both Silverman (2000) and Mason (2002) observe that triangulation of methods can be complex, as different methods can produce quite different data that is not necessarily simple to compare and do not always add up to a complete picture of the situation (Coffey and Atkinson 1996). Nevertheless, I have found that such comparison has contributed an additional dimension to this project, perhaps most strikingly in the differences in espousing and enacting, described in chapter 7. Close liaison with Warwick-Giles, whose related PhD project is referred to above also facilitated additional, though more informal, triangulation.

To strengthen validity, others (Pollitt, Harrison et al. 1990) also suggest using a ‘counterfactual statement’ to enhance validity. For this project, the statement would be
‘what would happen if the HWBs did not exist?’ and this is discussed in more detail in chapter 7 in relation to health inequalities.

A research diary (Silverman 2000) was intermittently kept as a record of my thinking and development and to help reflect on the research and my progress. In terms of reflexivity, I am aware that my EH background and interests influenced my approach to the concept of health inequality and how it can be addressed (Green and Thorogood 2009) and how it affected the reactions of respondents (Chew-Graham, May et al. 2002). This is discussed in more detail in chapter 11.

3.14 Generalisation
There are mixed views as to whether case study data can be generalised, as described by Flyvbjerg (2006) who faced significant resistance from colleagues regarding their views on the weak generalisability and validity of the approach, which he argues is misguided. Yin adds that one of the reasons for undertaking multiple case studies is to develop a ‘rich theoretical framework... which later becomes the vehicle for generalising to new cases’ (2009 :54), others feel that generalisation can be possible, however it should not be the sole aim of research and that thick descriptions are required for this to be worthwhile. Perhaps most relevant to this research is Donmoyer’s view that the specifics of the case study approach can be very helpful for practitioners who deal with individuals ‘for them, questions about meaning and perspective are central and ongoing’ (2000 :66).

3.15 Limitations
Potential limitations and the attempts to overcome them have been discussed throughout this chapter, for example in designing for validity and the generalisation of results. Although resources necessitated the location of case study sites to be within a reasonable travel distance, case sites were chosen for their characteristics rather than their accessibility; indeed one case study site was almost 2 hour’s drive from my home. In addition, I included interviewees from every English region and shared my findings at both local and national events and feedback from these additional sources did not indicate that the case study sites were untypical.

A significant limitation was my capacity towards the end of the data collection period when case study sites began to meet less frequently, but on coinciding days. I was fortunate that
by this stage the majority of data had been collected; however some difficult decisions were made on which meetings to attend. These decisions were based on the level and quality of existing data, the likelihood of discussion and debate of relevant agenda items at the meeting, and the agenda items listed. In addition, the minutes of the meetings I was unable to attend were read and at each of the case study sites my relationships with support officers was sufficiently well-developed by this stage that I was able to ask for clarification or additional information where appropriate.

Finally, my professional background did have an impact on the research at each stage, but I do not consider that this was detrimental and the implications are discussed in chapter 11. An unavoidable feature of the methods I used that data is understood and filtered by the researcher, however my supervision team have helped me to recognise and, where appropriate and possible, to mitigate these effects.

<table>
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<th>Chapter summary</th>
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<td>Qualitative methods, specifically semi-structured interviews, observations and document analysis were used to answer research questions of an exploratory nature relating to the development of HWBs, how they approach tackling health inequalities and the role of EH within this. A combination of longitudinal case study sites and contextual sites were used to ensure that all English regions were represented. Data was analysed thematically both inductively and deductively and the research was designed to ensure validity.</td>
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Introduction to results chapters

The following section covering chapters 4-10 describes the research results by theme, covering the HWB, health inequalities and environmental health elements of the research, with some overlap.

Chapter 4 discusses findings relating to structures; constitutional matters and agenda setting, including membership issues; sub-structures and ‘local’ HWBs; communication; and the impact of local politics, including elections during the HWB development phase.

Chapter 5 describes tensions in the new PH system, in particular between LA politicians and health services; between LA officers and health services; and the consequences of these.

Chapter 6 covers the interface between HWBs and CCGs, including the historical context; relationships; CCG representation, attendance and participation at HWBs; and HWB influence on CCG structures.

Chapter 7 details the differences in espousing and enacting in relation to health inequalities, including responses to the Marmot review and prioritisation; possible measurement of success; and the role of EH.

Chapter 8 highlights the role of EBP in the new PH system, and how this impacts EH.

Chapter 9 discusses the ‘double invisibility’ of EH, possible reasons for this, and how this ‘invisibility’ might be overcome.

Chapter 10 looks at the role of EH in the new PH system, including issues around the distinctiveness of the occupation; the perceptions and responses of EH practitioners and managers; and the impact of austerity.

Quotes from interviews, notes from observations and documentary data are used to illustrate either typical situations or unusual or contrasting issues. This provides an insight into the content of discussion in and around emerging HWBs and from EH practitioners and managers.
4 Structures, constitutional matters and agenda setting

This chapter explores structural and wider constitutional issues which arose during the development stages of HWBs, including matters around membership, sub-structures, ‘local’ HWBs, decision making, communication, and will also touch upon the role of politics, particularly the impact of local electoral cycles.

As I have discussed in the literature review, this research took place during the ‘pre-shadow’, ‘shadow’ and early ‘live’ stages of HWB development, from December 2011 to June 2013, during a time when there was great central government commitment to the idea of localism. As a result, much of the data was collected during a time of constitutional evolution and uncertainty in an environment where local decision-making was promoted. HWBs went live in April 2013, and local elections were held in May 2012, the outcomes of the latter significantly changed the make-up of two of the case study HWBs. The practice of running in ‘shadow’ form is unusual in LG, but a HWB support officer (ID2, site 3) clarified in an informal conversation that the approach is commonly used in healthcare.

To set the scene, a typical case study HWB meeting would be held in the committee room of the main council offices, some being more easily accessible than others; for example, site 2 feeling ‘out of town’ with ample parking, whilst site 3 was located centrally, but parking was expensive and required a 5-10 minute walk. Committee rooms are generally equipped with microphones and audio-visual equipment, although microphones were not provided in some rooms used at site 3, which at times made accurate note-taking difficult.

The layout of each room comprised a central table, around which HWB members sat, headed by the Chair, usually accompanied by their support officer. Where reports were given by non-HWB members, they were often (but not always) permitted to sit at the central table. Most HWB members were provided with name plates when the HWBs went live, although the circular nature of most central tables often made it quite difficult to identify speakers, particularly where they were unfamiliar or attending the HWB for the first time. Observers generally were provided with seating behind the central table or at the edges of the room, and at some sites this observation area was very crowded. The most
crowded meeting observed was at site 1 following national criticism of the local foundation trust. At some sites, refreshments were provided for observers in the form of water and tea and coffee.

Most HWB support was provided by a combination of PH and LA committee staff, although case study site 2 was unusual in that it appointed a dedicated member of staff to project manage the shadow stage. Site 2 was also keen to be seen as a national leader and this appointment enabled them to play a nationally visible role as an ‘early implementer’, with John Wilderspin, at that time the national HWB lead attending an observed HWB meeting.

The frequency of meetings varied greatly between sites and also at the same sites over time. The majority of case study sites met monthly during the pre-shadow and early shadow stages and also held additional development sessions outside formal meetings. The frequency of meetings tended to lessen as HWBs went live, settling to bi-monthly or quarterly as they became more established. Site 4 experienced a period of cancelled meetings due to poor attendance during the summer of 2012, and this was felt to be a concern by some interviewees at the site who were concerned by the apparent lack of commitment and a need to deal with heavy agendas during the shadow phase. Other commentators have highlighted the need for business to take place between meetings, where they are infrequent (House of Commons Select Committee on Health. Communities and Local Government Committee 2013). Most meetings lasted from 1-2 hours, depending on the chairing style and matters discussed.

This research has found that the policy of localism has led to a wide variation in HWB structures and other constitutional matters, and local variation has also been noted by others (Coleman, Checkland et al. 2014). Tensions in the new PH system are discussed in detail in chapter 5.

4.1 Membership
The matter of HWB membership was a thorny issue at the majority of HWB sites, with HWB chairs and support officers attempting to achieve a balance between the inclusion of all relevant parties and creating an unwieldy board with too many members for effective
decision-making. Member numbers varied considerably, ranging from little more than the statutory minimum (6), to around 40 members at one authority in a largely rural two-tier system. The existence of sub-structures did not appear to be related to the size of the HWB and sub-structures changed over time during the developmental stages.

As I have discussed in the literature review, central government published a statutory HWB membership list, which provided a starting point for many HWBs. Decisions on membership appear to have been made by the HWB chairs, leader of the council (often the same person) and HWB support officers and in some cases also involved the LA cabinet. There were very few discussions on membership seen in HWB meetings, with the exception of some fairly minor changes at site 2, which were approved by members following the presentation of a report. At some sites, for example site 1, it was felt that the DPH also had a role in membership decisions, whereas HWB member ID11 at site 2, felt that the process had been officer-led.

A HWB chair with a mixed LA and health service background explained the unusual characteristics of HWBs, and how the idea was grappled with locally in the early stages;

‘..in the early days it was more about questioning how are we going to do this. We know what the health and wellbeing board is supposed to do; what kind of a board is it going to be? Because it’s a weird kind of structure. I’ve chaired the county council here a long time ago now, but I’ve chaired lots of boards, lots of meetings, been involved in lots of outside bodies, but never have I chaired a meeting where members are county council officers and GPs and a variety of different people.’

(HWB member ID10, site 2) (my emphasis)

The chair also explained the decision making process on HWB membership at upper-tier case study site 2, including predicted changes as the board went live. This view was shared by several other interviewees, who were keen to stop their HWBs from becoming unwieldy;

‘... we’d keep it as tight as possible, have the major commissioners on it, but make sure that the sub structures reflected the wider health community. So to begin with
we had the three major players: adult social care, its director and its lead member, children and young person services, its director and lead member, the CCGs, or the PCTs as they were then but we all knew that would translate into the CCG, chairs. We decided very early on to have two LINks reps. That’ll change when Healthwatch comes in. But also, because this is a two tier area, straight from the start we had two district leaders on, because you can’t deliver this agenda totally without commitment and support and the resources that district councils bring. So that was it essentially.’ (HWB member ID10, site 2)

Decisions on the appointment of the chair appear to have been made by either giving the role to the leader of the Council (site 4), or the lead member for health and wellbeing (sites 1 and 2); or unusually, as in site 1, there was a ‘gentleman’s agreement’ on the appointment of an independent chair following local organisational restructuring; this position reverted to the leader of the Council when the HWB went live, however the individual who took the post was not the predicted person, as they lost their seat in the May 2012 elections. To reveal more details about the background of the original chair would compromise confidentiality, as very few HWBs have independent chairs and the deep local healthcare system knowledge of this individual was a relevant factor in their appointment.

Many HWBs faced challenges when deciding which, if any, non-statutory members should be included, although no sites were found to have restricted themselves to the statutory minimum. The following comment gives the opinion of a HWB member on the representation of LA services in a two-tier area (the suggestion had not been acted upon at the time of writing);

‘..my specific suggestion was that the seats, however many, given to the District Council should go to the key roles, because, I think, it’s really damaging not to have Environmental Health and not to have Housing represented around the table, that, I think, is a real disadvantage for us.’ (HWB member ID20, site 1)

The role of EH in the new PH system is discussed in detail in chapter 10 and is omitted here to avoid duplication. Another interviewee felt that only people with commissioning influence on health inequalities should be included;
'.. the first thing we tried to do was get as many people round the table who would be able to influence commissioning related to health inequalities... there was still a lot that weren’t going to be represented which made it inevitable that if we were going to change the membership we were going to disappoint some people, so it’s better to have a much smaller board that’s more functional.' (HWB support officer ID6, site 3)

A CCG member of a HWB felt that it was important that all local CCGs should be directly represented and touched upon challenges in agreeing HWB membership at case study site 1, which is in a two-tier area;

‘I think we might have been consulted about whether we thought all the CCGs should be represented and we said definitely yes, because otherwise there would have been perhaps 1 GP or 2 and we felt quite strongly that the whole point about having CCGs working with the health and wellbeing board was to ensure good representation, and as you know we ended up with a silly numbers game about districts and everybody suddenly wanted to be on the health and wellbeing board.’ (HWB member ID17, site 1)

Several interviewees expressed the need to try to keep a balance between LA and CCG members on their HWBs, primarily due to voting implications, where the view was either that the democratic voice of the LA should have the greatest weight or that health and LA representatives should be evenly balanced. This was often given as a reason for limiting board membership of LA officers, such as EH and housing and the quote below explains the considerations at a case study site;

‘..if you’re trying to maintain a belief that there is a balance between the Local Authority and the NHS and you exponentially increase the amount of the strategic directors and councillors sitting on the table, it doesn’t send the right image out really.’(HWB support officer ID6, site 3)

Many interviewees described how the HWB and sub-structures had been developed from existing groups, and this phenomenon has also been noted by Coleman et al (2014). Others have observed that in some areas there was an existing system of close collaboration (Tudor
Jones 2013). The following comment from a EH manager at a district council context site is illustrative;

‘..the health and wellbeing board has been long established in [X county], so, you know, the principles of working together with health and the District Council, well the housing portfolio holder from [X district] had a seat on this ages ago, before the restructure came out, so it’s good that it’s been well established and those conversations have been going on..’ (EH manager ID35, site 8)

An EH manager noted this trend and described the need to change the people and not just recycle the previous arrangements;

‘... I’ll look back in a year’s time and think, well, it’s just the same old, same old, nothing has really changed, because I’ve been involved with the NHS for a couple of decades now and I’ve seen restructures, I’ve seen different GP structures, to the PCT’s, they come and go with just the different names, and it’s the same people pop up in different structures... You need to change the people sometimes, not just the structure and I’m seeing it happen now’. (EH manager ID41, site 12)

At site 3, following local elections, the new chair changed the structure (restricting membership) and shifted meeting frequencies from monthly to quarterly. One of the reasons they gave for these decisions was attendance of senior of people;

‘..actually if you look at the minutes carefully you will see that the attendance and the seniority of people coming just dipped pathetically.’ (HWB member ID7, site 3)

The support officer at the same site was also concerned about maintaining the credibility of the HWB;

‘We did have difficulties ... trying to get people to actually attend the board meetings. Obviously if you’ve got a large membership with a low attendance, that gives you credibility issues whereas I think a smaller, more focused membership gives you a much easier amount of people to manage..’ (HWB support officer ID6, site 3)
All of the case study sites viewed attendance seriously and CCG attendance issues are discussed in more detail in chapter 6.

4.2 Representation of non-statutory members
There were four main strategies seen by lower-tier LAs and other non-statutory members who sought representation and influence at the HWB. The first was direct representation on the HWB (for LAs this was usually via elected members); the second was representation on sub-structures (for LAs this was usually by officers); the third was to set up (and also to encourage and facilitate the setting up) of ‘local’ health and wellbeing boards; and the forth was to attend the HWB meetings as observers and to contribute to the discussion wherever possible. In a similar LA context, Boyd and Coleman (2011) noted two distinct approaches used by health scrutiny committees to influence decision makers; co-operative and adversarial, with co-operative strategies dominating. Applying these approaches to strategies used to influence HWBs, it appears that the co-operative approach was very much in evidence, although further research during the live stage would be useful in determining whether a more adversarial approach emerges.

The District Council’s Network evidence to a recent Select Committe highlighted the issue of adequate district council representation ‘it seems contradictory... given the prominence of the prevention agenda -that whilst CCGs have a statutory role, there is no obligation to involve districts beyond the production of JSNAs’ and the committee recognised the issue as a concern (House of Commons Select Committee on Health. Communities and Local Government Committee 2013 :32). To find a practical solution, in some areas, particularly where there were a large number of district and borough councils, members were chosen to represent others. At case study site 1, there were five such LAs and representation in terms of members on the HWB grew over the shadow period from one to five. A district council member of the HWB explained some of the negotiations between the different LA tiers, emphasising the need for district councils to be involved in decision-making;

‘Originally the County, in their usual manner said ‘We will have one person to represent all the five Districts’... and what effectively I said to them was ‘Well it just isn’t on really, because you’re missing a trick’. They said ‘What? What?’ I said ‘Because if you start .. saying we have decided this – will you please put it in hand..
we shall listen and most probably try but... ‘if you’ve got the five of us there and we come back and say I’ve just been to the County and what we are all going to do is... if you’ve given us ownership ... we’ll do it, because we’re on board, rather than receiving an instruction from on high’, because after all, they can say what they like – we don’t have to do it.’ (HWB member ID22, site 1) (my emphasis)

This view was supported by an EH manager at another site who recognised the autonomy of the different district councils and their role in prevention;

‘If you want District Council buy in you’ve got to work with us. You’ve got to accept the role we play because you cannot deliver this without us and you’ve got to accept that in a County like [area] there are [number] very different Local Authorities’ (EH manager ID44, site 15)

A district council EH manager explained that whilst it was desirable that all lower-tier LAs were directly represented, in their area it was probably not practicable and this was recognised by others in similar positions, particularly in areas with a large number of district councils;

‘...and what our members would like is a representative from each of the twelve [lower-tier LAs], which it gets to a size where it’s just not going to work. I think there’s already about twenty odd on the County Health and Wellbeing Board, which is getting to a stage where nobody can make a decision..’ (EH manager ID32, site 5)

Interestingly in some cases, most notably at site 1, even where non-statutory members were present, those representing lower-tier LAs contributed to the debate very infrequently. A member of a lower-tier authority at a context site added the issue of balancing LA numbers on the HWB, particularly in areas where historically relationships between the LA tiers have been poor;

‘[relationships] they’re pretty awful, as with every two tier, there were power struggles... because, you know, the county council don’t want the district reps outweighing in numbers,’ (EH manager ID35, site 8)
A HWB support officer and EH manager explained how the district and borough councils in their area worked with the HWB (and on other matters) at case study site 2;

‘Across the districts, we agree the strategic priorities for our work across the county, and then one chief exec will be the lead on certain of those priorities. Because partners can’t work with all seven of us, you know, it’s absolutely barmy...’

(HWB support officer and EH manager, ID8, site 2)

There were mixed views as to whether lower-tier LAs would be best represented by elected members or officers, with the overwhelming majority of representation by councillors;

‘There is no District Council Officer representation on the Board whatsoever, which I think is a real weakness.’ (EH manager ID44, site 15)

In some areas, districts were represented by both elected members and officers, however this appeared to be rare, with district officers more likely to find places on sub-structures than the HWB. At site 1, in contrast to the situation in many sites, officers reported apathy towards the HWB by district and borough councils;

‘Well, I went to see the District chief execs before this was actually formalised to try and nudge them into going back to structure it differently, to look for roles, or to ask for their five seats and I didn’t detect any appetite for change.’ (HWB member ID20, site 1)

There were also mixed feelings about whether providers (such as foundation trusts, private sector or third sector providers of services) should be included as members of the HWB and this is reflected in the literature, where concerns have been reported about conflicts of interest (Humphreys 2013);

‘I think if we had providers round the table there’d be much more tension because there are providers that [name] Council enjoys working with and there’s providers that [name] Council would quite like to see disappear, and that plays out in all sorts of ways.’ (HWB member ID26, site 4)
A HWB support officer at a different case study site gave a contrasting view, but explained that the issue is not straightforward;

‘I was very keen to have NHS Acute providers... but we have so many acute providers, trying to find one who would represent the interests of all of them just proved to be a negotiation that we just couldn’t conclude.’ (HWB support officer ID6, site 3)

Different HWBs managed the inclusion of providers in different ways, for example at case study site 1, providers attended HWBs and were permitted to contribute to debate, but were not allowed to sit at the main table with HWB members and did not have voting rights; whereas case study site 2 had found a workable solution by including providers in HWB sub-structures. At several sites, particularly at Site 1, where there were long-standing concerns about mortality rates at the local district general hospital, a representative of this provider was also required to give an update at most HWB meetings. Additionally, the statutory inclusion of GPs, being providers of primary care, somewhat confused the issue, as described by one HWB member, (however CCGs are included as commissioners rather than providers of services, although it is unclear whether this distinction is appreciated in practice);

‘... there’s a contradiction really because of all the doctors sitting round the table, and they’re providers as well.’ (HWB member ID25, site 4)

Voluntary sector representatives were included in a variety of ways. At site 4, they were included as members of the HWB whereas at other case study sites they tended to attend as observers, contributing to the debate where possible, the opportunity for which appeared to depend greatly on the style of the chair. The voluntary sector representative at site 4, explained why they had been included;

‘...there's a strong belief that the voluntary and community sector plays a role in delivering better health, tackling health inequalities... ’ (HWB member ID28, site 4)
A HWB member at the same site felt that the Chamber of Commerce, providers and members of the faith community should be included on the board, but at the time of writing this had not happened;

‘I would also involve a representative from the Faith Community somehow... an awful lot of people, in whatever form it is, worship sometime during the week collectively and if you’re living that out, whichever your religion, or whatever it is, trying to promote Health and Wellbeing must be part of that.’ (HWB member ID25, site 4)

All the sites included in the research had at least one non-statutory member, most commonly this was in the form of representatives from lower-tier LAs in two tier areas, but did also include additional elected members, and less commonly, the police, voluntary sector and other bodies. The inclusion of the police has also been reported by Staffordshire, (Ellis, Curry et al. 2013) although this site was not included in this research.

4.3 Sub-structures
The majority of HWBs had, or were planning to, set up sub-structures, even where they said that they were trying to avoid them. There appeared to be two forms of sub-structure; the permanent arrangement, for example an officers ‘steering group’ and the ‘task and finish’ arrangement, for example on the JSNA or other specific project. The functions of these varied, but were often used as a way of including those groups, who were not given a place on the HWB itself, such as EH and housing. A common sub-group was for the JSNA, and some had considered how its work would be made accessible to the public;

‘..., I think, should be necessarily public, or made available to the public, in terms of minutes, or what’s been discussed but... that’s where the mini engine rooms really ought to click, so actually the health and wellbeing board becomes the overseeing board...’ (HWB member ID5, site 3)

Some interviewees spoke of strict criteria for sub-structures;

‘The very first stage of this, people did begin to develop a rather impressive structure that would underlie the board and support the board. There are no
resources to actually implement this, so.. we said quite early on was- we are not
going to build anything underneath it, unless there is a very good reason for it.
Unless one of the partner agencies can supply the resources for it and as long as it
doesn’t duplicate or replicate anything...’ (HWB support officer ID6, Site 3)

Others felt that sub-structures had been of limited value in the past;

‘...there’s been a deliberate decision not to create lots of substructure underneath
the board in the early phases... there’s a feeling that under the old PCT there were
millions and millions of meetings without too many outcomes.’ (HWB support
officer ID30, site 4)

Some sub-structures became quite complex, for example an EH manager described working
on a structure within a HWB sub-structure and this was not uncommon;

‘...because it is a large working group, we’ve actually got a little sub working group
now, so it is where your complicated structures start emerging, don’t they?’ (EH
manager ID35, site 8)

There was some confusion about how sub-structures were constituted or would work in
practice in relation to the HWB, however it should be borne in mind that much of the data
collection for this research was during the shadow and pre-shadow phases when structures
were emerging rather than established;

‘So when we say no working group, there's a JSNA working group. I'm not sure
whether it's a formal subgroup of the board or how it's been established.’ (HWB
member ID28, site 4)

There was debate about the role of some HWBs in performance management and
measuring success and this is discussed further in chapter 7, (in relation to tackling health
inequalities). Site 4, for example, was considering setting up a sub-structure for this
purpose.
Some sites used sub-groups as a way of including officers at district and borough councils, however at two-tier site 1 this caused some difficulties, as lower-tier LAs are independent of each other and were keen to retain their individual voices and representation;

‘...the demands from the [sub] committee want to see a single voice really and we’ve always maintained that we would want to have a separate voice, so I’m not sure how that one is going to be resolved.’ (EH manager ID23, site 1)

There were several proponents of ‘task and finish’ groups (meaning short-term groups used for a specific project and then dissolved) and a general lack of enthusiasm for long-standing sub-structures;

‘... there will be a development of subgroups of the board looking at specific issues and bringing them back to the board. I think that’s a model that I would prefer.’ (HWB support officer, ID27, site 4)

There were also other existing boards and groups, for example representing children, which were linked to HWBs in some sites, for which the following comment is illustrative;

‘The Children’s Partnership, which is just developing its governance to report in to the Health and Wellbeing Board and by extension the Adult and Children’s Safeguarding Board is reporting to that. The next things we’re trying to work out is really where things like the Community Safety Partnership and Local Strategic Partnership and the Local Enterprise Partnership sit.’ (HWB support officer ID6, site 3)

Even where there was a general lack of enthusiasm and funding for sub-structures, they existed either as permanent arrangements or ‘task and finish’ groups. There are also a wide variety of other arrangements where the HWB connects to other health and LA system structures.

**4.4 Local Health and Wellbeing Boards**

Some district and borough councils have created local HWBs to try to influence the county level HWB and three different context site interviewees were working in sites with these
arrangements. In all of the cases where EH interviewees mentioned a local level board, EH managers appeared to have been far more instrumental in setting it up and driving the agendas than they were at county level HWBs, where they were largely ‘invisible’. An EH manager described the rationale for setting up their local HWB as an influencing body, focussing on the value of local knowledge held at the lower-tier. They also explained that a representative of the county HWB attended to provide updates;

‘I think that’s one of the key reasons we set up the local health and wellbeing board, is to say because we’ve got the right people here, and actually county, because we live here as well, we are, or we deal with these people every day, that actually we really do know our district. So when we say actually we think you need to do this, or we think that’s an issue you’re going in the wrong direction, you need to listen to us, so absolutely, it’s a strong voice.’ (EH manager ID47, site 18)

Several EH managers in district councils explained the benefits of their local HWB as demystifying the County HWB, its members and processes and giving a broader perspective to those involved;

‘..From a health point of view... it certainly gives you a better understanding of what’s going on, so you get a wider perspective..’ (EH manager ID36, site 9)

An EH manager in a two-tier system also mentioned that neighbouring authorities had created a joint local HWB and this research indicates that local HWB structures are in places in areas of at least three geographically spread English regions. Interviewees generally had a limited awareness of structures in other parts of the country.

4.5 Observers
During observations, it was notable that many observers, generally numbering in the region of 20-30 at HWB meetings, were from local providers, voluntary groups or other parties such as pharmacists and other LA and healthcare employees. Some people were regularly seen at meetings, for a example, a third sector provider at site 2, and foundation trust managers at site 1, whereas others were only seen at one meeting and did not appear to return. There were very few, if any, members of the public seen, particularly in the shadow stages. Opportunities to contribute to debate greatly varied and this appeared to be related
to the style of the chair and professional relationships with HWB members and the known expertise on the business of the day. Site 3 was not particularly welcoming to observers and did not encourage their contributions to the debate, whereas, sites 1 and 4 did so. It is clear that the attendance at HWB meetings as a strategy for involvement had varying levels of success, but nevertheless it did give an opportunity for networking with members, as seen at the beginning and end of HWB meetings, although this could often involve a long wait to gain the attention of the member concerned and some were more open to approach than others. It was clear that much of this post-meeting networking was with people already known to HWB members.

4.6 Channels of communication

The research has shown that at many HWBs, board members are required to represent others, for example an elected member representing their LA or other LAs. Channels of communication with representatives on HWBs or sub-structures did not generally appear to be working effectively, and this was seen both in interview data and during observations where lower-tier LA members often made a minimal contribution to meetings, particularly during the shadow stage. The difficulty in establishing effective routes of communication was described by an EH manager at site 1;

‘.. there are occasionally emails that get circulated to the chief exec and then come down to me... because it’s such a big agenda and a lack of real understanding of how we engage, how we can influence this and just understanding what’s going on..’ (EH manager ID23, Site 1)

Similarly, an EH manager in a two-tier system described poor formal communication links with their HWB representatives;

‘... no mechanism has been set up, no formalised one as to how we connect with those people ..’ (EH manager ID32, site 5)

Another EH manager in a two-tier system described difficulty in creating sustainable communication links into the HWB;
‘So having a Chief Exec from another Local Authority representing all the Districts is not great. I’d say that’s better than having a Councillor representing, so the difficulty is getting and maintaining information and feeding that information back up through the chain.’ (EH manager ID37, site 10)

An EH manager described difficulties in communicating directly with the HWB, as there were 11 district and borough councils and explained that the route of access for them was via the PH team;

‘...so he is saying to the board, look, we can’t engage with every District, so through my Public Health team we will set up protocols so that the local priorities can be reflected in our strategy.’ (EH manager ID41, site 12)

Another EH manager has identified their route into the HWB being via commissioners;

‘...only commissioners were going to be on the Health and Wellbeing Board – [the decision-makers said] there was no point in having anybody else on it and the important position was then going to be, from our point of view – Environmental Health – was going to be having contact with one of those commissioners.’ (EH practitioner ID45)

A HWB member representing other lower-tier LAs at site 1, explained that they had been asked to feedback after meetings;

‘But one of the lead members from one of the other councils said that he thought it was fine and he hadn't got any complaints. But he thought it would be nice after every board meeting if as a district rep I could go back to them with just the headlines of what we've talked about.’ (HWB member ID9, site 1)

There appears to be significant scope for improved communication links between HWB members and the people they represent, if structural representation is to result in meaningful engagement locally.
4.7 Decision making and agenda setting

HWB meetings were generally held in a traditional LA format, starting with apologies, minutes of the last meeting, etc. This was then followed by several agenda items either for information or discussion and decision-making. To illustrate, an agenda from site 2 immediately before it entered the ‘shadow’ stage, considered the following matters; position statement of the Chair on various issues including progress of the Health and Social Care Bill; HWB Governance, including agreement of terms of reference; NHS Commissioning Board Update; Public Health Transition Plan; and 7 other mainly substantial items. This example (not untypical across the case studies) shows the volume of business dealt with by a typical HWB during a bi-monthly or quarterly meeting.

The tone of meetings and decision-making processes varied considerably between sites, with some chairs permitting much debate, whilst others felt that discussion and any disagreement should take place outside HWB meetings. Site 2 in particular held very little debate during meetings, limiting the scope of the observational data collected. This approach was explained by the chair;

‘I’m determined that we will never have a vote on the board. We’ll do it all by consensus. And if there is a danger of falling out over something we’ll take it away and sort it, but not in public at the board.’ (HWB member ID10, site 2)(my emphasis)

A HWB support officer at site 3, described the need for some business to happen away from the HWB, but the practicality of this was an area for development;

‘... a lot of the work we are going to do is going to have to happen outside the formal board meetings, because you just can’t get everybody round the table and I think that was our experience from the local strategic partnerships, where we used to have forty members which, you know, it’s not really practical... we have to do more work on figuring out how this Board does actually come together outside of the official meeting cycle, because as yet it’s not really doing that... ’(HWB support officer ID6, site 3)
A HWB member at site 1, also explained their reasoning for the need to meet outside the formal HWB, and as I have described, the ‘transactional’ nature of meetings at this site was noted in my observations;

‘...we meet as a Board however often we meet for two hours, [name] ’s mission as Chair is to get us through that agenda with sufficient contribution on each to have got away with actions or a way forward, to keep to time, and to manage the meeting. My agenda is for us to have engagement and for us to own the issues and agree ways forward. Now the two of those are mutually incompatible, which is why I keep pushing this notion of we need to do work outside of the meeting... so that we can grow the relationships and the culture and the joint working, otherwise it’s just going to be a transactional meeting every couple of months that doesn’t really add much value.’ (HWB member ID19, site 1)

It was not always clear how HWB agendas were set, although an officer ‘steering group’ was a common arrangement;

‘..I’m part of the steering group that shapes agendas, development sessions and stuff like that. [the members are] .. Both the CCGs, one of the officers that supports Health Watch or Links now, the director of adult social care, director of public health, director of children and young persons services... So it’s key officers really. (HWB support officer and EH manager ID8, site 2)

An EH manager at another site described a similar group, which had fallen away following a recent appointment resulting in agendas felt to be lacking in scope and ambition;

‘...having the agenda set by somebody who doesn’t have any real knowledge of any of these sort of health aspects, just leads to generic agendas being set... It’s not a world changing agenda is it really?’ (EH manager ID40)

HWB members who were not part of an agenda setting group (typically elected members) generally stated that they could add items to the agenda, if they felt the need, but most interviewees had not taken this opportunity and were reacting to rather than shaping the work of the HWB. Observations also showed that at most sites conversation and debate was
dominated by certain individuals, most notably at site 3, the elected member who later became the chair. The notable exception to this observation was seen at site 4, where the Chair appeared to pay special attention to ensuring that all voices were heard, often specifically asking individuals whether they had anything to add on the topic of discussion.

The research indicates that there is variation in how decisions are made at HWBs, but there is a significant level of work which is, or is planned to be, carried out outside the HWB. This is interesting in that from April 2013 HWBs were required to meet in public, however observations have revealed that the content and level of debate heard in public at some sites is minimal, with a clear intention at some sites that disagreements will be debated privately. Public access to the work of sub-structures appears to be an area of development. In addition, it is clear that at many sites, officers rather than elected HWB members (with the exception of some chairs) drive the agendas of HWBs, although HWB members did feel able to add agenda items if they wished.

4.8 Politics
Only one HWB (site 3) was found to have included opposition members and there is no legal requirement for political proportionality, as is often required for LA committees. When asked about the decision to include opposition members, a support officer (ID2) explained that when they looked at other partnership arrangements and the overview and scrutiny procedure, both included opposition membership, there was also a feeling that the leading party might change after the forthcoming elections and they wanted to secure some continuity. This transpired to be the case, and one of the opposition members of the HWB subsequently became the chair. A support officer at the site gave more detail on the decision and explained why opposition members might be excluded in the future;

‘..when we originally set the board up was recognising that the Local Authority was on a knife edge in terms of elections, so we needed to make sure there was definitely some continuity from one year to next, so we had quite a substantial opposition representation the first year. In the second year we were talking about whether that was actually needed. Because I think, I think it’s a fair point that the people sitting round the table have got to be the people that are influencing their own
commissioning budgets. In terms of the opposition of elected members, they don't actually have a commissioning budget.’ (HWB support officer ID6, site 3)

A HWB support officer in a two-tier system expressed an interesting view that party politics should not be an issue, and with the exception of site 3 it was not overtly observed at meetings. However, this contrasts with and is a by-product of the central government intention to use HWBs to put democracy in health;

‘..from the district representatives, one's a Lib Dem councillor and one is a Conservative councillor. But they're there because they are nominated by the leadership of the districts. I think where the political proportionality stuff will come in is in the scrutiny; you know, how is the work of the health and wellbeing board scrutinised; how will that work? And actually, ... party politics shouldn't come into it, you know. (HWB support officer and EH manager ID8, site 2)(my emphasis)

Interestingly, the opposition member who became the chair referred to in the above quote had used the HWB meetings from the beginning to make political points, and this had been raised as an issue by other members of the HWB, both at board meetings and outside. This was a notable feature of site observations and was even recognised by the member concerned;

‘It created an unfortunate dynamic because I think despite my best efforts to reign in my own behaviour it did result in there being quite a lot of polarising party political tit for tat in that forum.’ (HWB member ID7, site 3)

An EH manager eloquently described their observation of differences in strategic thinking on health from elected members of different political persuasions and the effect of political views on decision-making at the local level;

‘...so the Labour [political] approach to health was: we should have rules to stop people being exploited by Coca Cola, and Cadburys, and all the other Olympic Sponsors, and tobacco companies and the Lib Dem guy was saying: No we need to make the population self sufficient and self reliant... When you don’t have the opposition on there you don’t get an alternative perspective so, the Labour
Councillor will be fighting just for the Government that issues bans on this and bans on that and increase benefits and that sort of thing, and the Conservative one will just be saying that, well if people can’t look after themselves, we should just throw them into the poor house.’ (EH manager ID40)

Many officers discussed the practical need to achieve cross-party support for the work of HWBs;

‘..there is definitely cross-party support, they recognise it as being something that’s very important, very high profile and its essential in [site 3] that we get it right, so that that, you know as officers that’s hugely helpful, because if you’re trying to sort of balance, you know one view against another it can get a bit difficult but that’s not the case here.’ (EH manager ID4, site 3)

Local politics predictably appeared to play a greater role in the site with opposition members included, compared to those where only the controlling party members holding key positions were included, however the strategy did allow continuity where local elections changed the controlling party at that site. Officers involved in HWB often expressed the need to gain cross-party support, although it was evident that people with different political persuasions may take different views on health decisions for their local areas, as they were representatives of specific wards or parishes in addition to political parties.

4.9 Meeting in public
Although I have discussed decision making in public above, approaches to meeting in public varied greatly across the four case study sites. Site 3 held all HWB meetings in public, including from the shadow stage, and as it went live had arranged for live tweeting of meetings by PH support staff and was considering the use of live web streaming; site 2, met in public from the start of the live phase, but the number of non-public observers was significant during the shadow phase (often between 20 and 30); site 1 met in public from the beginning of the ‘shadow’ phase in April 2012 and had significant attendance of
observers from providers and other organisations during this time, but very few, if any, members of the public attended; site 4 opened to the public only when it went live, but there was no indication that they would have preferred to continue meeting in private. A support officer from site 3 discussed the pros and cons of meeting in public from a very early stage;

‘I think our instinct to begin with, having public meetings was useful because it raised the profile of the Board, it got people into working in a very business-like way, but it hasn’t allowed them freedom to have those open and honest conversations with each other about how this is actually going to work. So I feel we’ve missed some development opportunities...’ (HWB support officer ID6, site 3)

As I have discussed, all sites carried out a significant amount of work outside HWB meetings. All four sites used the council offices for most meetings, although one HWB member felt that this should not necessarily be the case and was keen to encourage a wider group of observers to attend by varying the location of HWB meetings;

‘...a bit of psychology... let’s go and meet at [a hospital], let’s go and meet at [another hospital] let’s go and meet at community and mental health services, let’s go and meet at Age UK, ... because nobody really turns up to the meeting, apart from people like yourself...’ (HWB member ID21, site 1)

4.10 Conclusion
HWB structures and sub-structures vary greatly across England, however there are some similarities, for example in the development of ‘officer steering groups’ for agenda setting and action on decisions and for ‘JSNA working groups’ and other task and finish groups. There are also variations on the level of debate held in public and away from the HWBs, which at some sites limits the ability of members of the public to appreciate their representatives understanding of and opinions on the policy matters being considered. Routes of communication between HWB members and those they represent were also often ill defined and not working to their full potential. There were also a variety of strategies used by individuals and organisations with no place on the HWB to achieve influence, however the success of these strategies was difficult to measure at this early stage.
Finally, for all the discussion on structures and sub-structures, as a HWB chair eloquently said, the content of the HWB meetings and what action follows them is what matters;

‘...because one thing I hate doing is being in meetings that serve no purpose’ (HWB member ID7, site 3)

Further research looking at HWBs as they develop during the live phase would help to ascertain whether the meetings do lead to action and become local health leaders, or merely ‘talking shops’ (Humphries, Galea et al. 2012).

Chapter summary

The policy of localism has led to the development of variety of HWB structures and ways of working, and individuals and groups with no place on their HWBs have adopted a variety of strategies to attempt to be heard.

This chapter addresses question 1 as it identifies how HWBs were developing and functioning within their local contexts.
5 Them and Us: tensions in the new English public health system

This chapter describes some of the tensions which were evident between different players during the Public Health (PH) transition, shadow period of HWBs and CCGs, and as they went live, including how they were managed, and the ways identified for more harmonious relationships to be developed in the new system. This is not to say that all relationships suffered from tensions; more cordial relationships are discussed throughout this thesis.

As I have discussed in chapter 1, much has been written about organisational and worldview differences and tensions between health and social care occupational groups, and the various initiatives and efforts made to overcome these. There is less in the literature about clashes and tensions in other parts of the health and PH systems in LAs and the NHS.

The HSCA12 required two major structural changes involving the interface between LAs and health services: the first was the establishment of Health and Wellbeing Boards (HWBs), as LA sub-committees with CCG members; the second was the relocation of PH medicine staff previously based in the NHS to upper-tier LAs.

The interviews reveal significant tensions between various players and this is discussed below, however the same tensions were not always seen during observations of meetings. Notable exceptions include party political comments made by an elected member at site 3 (discussed earlier), which was objected to during the meeting by health service members of the HWB; and an acrimonious meeting at site 1 where a CCG made a decision to merge with a neighbouring area and this was criticised by LA representatives (both officers and elected members). Site 4 was notably convivial, even when discussing matters where a variety of opinions were raised, the chair ensured that all views were listened to and respected and that the outcome of each item was agreed by all.

The interface between HWBs and CCGs is discussed in greater detail in chapter 6.

5.1 Tensions between local authority politicians and health services
The statutory requirement for LA politicians, GPs and other PH colleagues with health service backgrounds to work together in HWBs is new and, as I describe in chapter 6,
required partnership building in difficult and pressured circumstances. A key difference was the introduction of the democratic process to health service decision-making (with the exception of the existing health scrutiny arrangements). A CCG representative on a HWB explained how much easier it was working in the apolitical NHS than in LAs with elected members;

‘I haven’t had to work in close proximity with the elected members when I’ve been working professionally before and that it is odd, I have to say... I think it’s so nice just to be in the NHS and be completely apolitical, you know, it’s just so much easier isn’t it? ‘(HWB member ID17, site 1)

This is an interesting comment, given that an explicit aim of the statutory changes was to democratise the NHS, as discussed in chapter 1. However others have described concerns around how difficult decisions, such as hospital closures will be made with the inclusion of local politicians in the new system (Coleman, Checkland et al. 2014). An EH practitioner explained the differences in where power lies in LAs and the NHS, and indicated that working in a LA situation could be an uncomfortable experience for health service colleagues familiar with top-down control and decision making;

‘I just think that working in local government is an anathema to many of them. It’s the opposite of where they’ve been. The NHS is top down. There might be anarchy reigning but the hierarchy is power descends from the top and the control over practice comes from the top. Local government is completely the opposite. You know, our saying was always that officers advise and members decide.’ (EH practitioner with national role ID33)

Similarly, an EH manager said that elected members in their authority had reported that the significance of their role was not understood and appreciated by colleagues with health service backgrounds. In contrast, at all at HWB meeting observations CCG representatives were seen to be respectful to elected members and to take their comments seriously;

‘[elected members have said] they’re feeling there are some cultural differences in that they almost feel like some of the NHS people coming across have not fully woken up to fact that elected members ultimately make policy and decisions.. the
members are clearly not feeling confident that the NHS staff know that – have really woken up to the fact that actually the members play a far bigger role and actually are effectively their boss...They may know nothing about Public Health but they’re the boss’ (EH manager ID46, site 17)

The same manager went on to describe the impact of perceived educational and class differences between medically qualified people and elected members;

‘There are a lot of medics, probably who are in some respects quite elitist.. with their qualifications and everything, and coming to an organisation where the person who is a cabinet member for health may not have qualifications. They may have no background in health. They may be from quite working class backgrounds, but they have the final say on the policy decision and it’s, wow, that’s a bit of a change.’ (EH manager ID46, site 17)

A HWB member who was an elected representative also recognised that GPs could become disengaged by the political process, and this is supported by an observation at site 3, where party political comments by an elected member were criticised by other HWB members;

‘Politicians love meetings, and if there’s nothing to argue about they’ll find something, because that’s what we’re about. GPs hate that. They will engage as long as there’s a purpose and a reason for it...’ (HWB member ID10, site 2)

Another elected HWB member, alluding to the aim of democratising health services, felt that this principle was not well understood by medical colleagues;

‘The interesting thing is, health has never been democratically accountable. And they [GPs] really, really, really don’t understand it.’ (HWB member ID18, site 1)

An elected member of a HWB (and former LA officer) felt that this lack of appreciation of the role of local democracy, and the level of consultation this resulted in was frustrating to colleagues with health service backgrounds;

‘There’s always been a bit of tension about how you operate, how you make decisions, the level of democracy you embrace... and I think health got a bit
frustrated with us now and again when we were saying well, hang on a minute, we need to consult a bit more about this, we need to talk about our wider council group and even in some circumstances to the public, and sometimes they were, oh do we really need to do that?’ (HWB member ID27, site 4)

From a different perspective, an EH manager described encountering difficulties in persuading elected members that there was a health role for the LA, however this challenge was not seen in the case study site observations;

‘..for some of our councillors, it’s obvious, because they get it anyway- for some of our, perhaps, more mature councillors who view health as health services,[they ask] ‘and why are we subsidising the NHS?’’ (EH manager ID41, site 12)

The new experience in working with elected members for a DPH with a medical background was anticipated by individuals within the LA at site 2 and steps were taken to prepare them for their new work environment;

‘... we spent quite a bit of time... just talking the politics, you know, in terms of expectations and stuff. Because actually, if you don’t know it, you walk onto a punch [and] you don't want to walk onto those punches.’ (HWB support officer ID8, site 2)

Others had noted that PH employees moving into LAs from the NHS had felt nervousness around the political arrangements and this had perhaps restrained their more challenging instincts, and this is supported by observational data from the case study sites, where the approach seen was generally consensual;

‘... public health staff are highly specialised and highly trained and as part of their qualification route, they’re asked to be challenging...so part of the role of the DPH is to be independent and an element of that is political, so things like the national smoking ban, if Public Health professionals hadn’t lobbied for big policy change, things wouldn’t have happened so it’s not just an organisational culture thing, ... what I’ve noticed in the early stages of the Public Health team coming in is, they’ve almost tried to compensate for not having this understanding of the political arena
and being too concerned about not being able to put things forward, because of being concerned about how it might be received. ’ (HWB support officer ID30, site 4)

There was a feeling amongst some interviewees that whilst LAs had attempted to prepare health service colleagues for working with elected members, LA officers and politicians had not necessarily made the same efforts to inform themselves about the health service their new colleagues would be coming from;

‘I'm not so sure that the local government bit has actually tried to understand the language and the culture of health. ’ (HWB support officer ID8, site 2)

The research findings indicate that the new relationship between elected members, GPs and previously health service based PH colleagues have in some areas started with a certain degree of frustration, mistrust and anxiety, at least on the part of those interviewed for this project. There are particular issues around the idea of democratising the health service in practice and the understanding and appreciation of the role of elected members, who are unlikely to have a detailed technical knowledge, in decision making. In addition, health service colleagues’ only experience of LAs might previously have been with health scrutiny, which can be seen as confrontational. However, efforts are being made to overcome these issues and to understand and appreciate the roles of other parties in the new system.

5.2 Tensions between local authority officers and health services

This research has found the involvement of HWB members in preparing the JSNA and JHWBS to be variable; in some areas they have been drafted primarily by the team of the DPH, with limited involvement of HWB members, whilst in other areas members have been more fully involved in the process. Commentators have called for HWB members to conduct an audit of their JSNA and to ensure that it is ‘owned’ by parties outside PH (Harding and Kane 2011). It was found that the preparation of these documents in the first year was often in the form of a ‘refresh’ of the existing JSNA and strategies, which is a practical solution given the early stage of HWB development, other pressures, and tight timescales involved. The JSNA was a regular feature on case study HWB agendas during
the shadow phase, and at site 3, the DPH was visibly exasperated at one meeting where there was an unexpected lack of agreement on local priorities from other HWB members.

In some areas, the historic relationships between health services staff and LA officers have not always been positive, as an interviewee explained;

‘There was quite a lot of bad feeling between what was the PCT and the council.’
(HWB member ID26, site 4)

At a more personal level, there were differences expressed about the approaches of various occupational groups. As I will describe in chapter 10, LA officers, in particular EHPs, see themselves as ‘doers’ and several commented on the lack of practical knowledge and skills and the different language used by PH staff from health services backgrounds. An EHP described their experience in working with formerly NHS-based PH colleagues;

‘.. they talk a different language, they’re a very unusual breed from my experience... they’re good, but they’re not practical problem solvers, whereas the EHOs are the guys on the ground, that have got that practical knowledge.’ (EH practitioner ID38, site 10)

This view was supported by a HWB support officer who had noted that LA officers were good problem solvers in contrast to PH colleagues. They also commented on a lack of willingness among health professionals to engage with the more practical preventative measures the LA could deal with;

‘We’ve had a lot of difficulty, because some of the health professionals are, like, ‘well, it’s not my job’ and it’s like, well yeah, but you could just tell us, we’re not expecting you to go around with your hammer and bang down people’s carpet!’
(HWB support officer ID30, site 4)

An EHP shared an illustrative anecdote about the differences between the work, attitudes and tolerances of health professionals and LA officers seen when they took a nurse on a work experience visit;
‘...we go to places other people don’t go. You’ll hardly find a Director of Public Health who has ever crossed a threshold in anger, they don’t do that. People come to them in surgeries and we go into people’s private places. Not just in their homes, but in their lives, we see them in all their dirt and glory. I’ll never forget, I took this nurse out. I took one into this HMO [house in multiple occupation] in [area] and it was a bit of a pig sty, and when we came out I said, ‘what do you think of that’ and she said, ‘well I thought the parlour was very dirty,’ I said ‘what was the parlour?’ and she said ‘well, that front room’. I said ‘that’s not a parlour, that’s their home. That’s where they eat, sleep and make babies’ and she said, ‘I feel quite ill, I want to go home now’. So, that was her work experience of one visit.’ (EH practitioner with national role ID3)

Another LA officer, who has a track record in implementing successful and innovative initiatives locally, had found the approach of NHS colleagues very frustrating;

‘... the biggest gripe that I have at the moment, is that I go to loads of meetings, especially with the NHS now, it’s a completely different culture, and I sit in meetings where everyone drinks a coffee, they eat the biscuits, they pontificate and they navel gaze about strategies and policies and visions and all the rest of it, and they don’t do anything about it...I’m constantly amazed at the people that just sort of turn up and talk and go away again. I think what do you actually do – I don’t know what you do with your money...’ (EH manager ID37, site 10)

Another EH manager also felt frustrated, this time about performance management in the NHS in the longer-term and aversion to risk taking in trying new initiatives with unpredictable results;

‘So I’m having similar battles with them about thinking in the longer term because they want to performance manage everything, because in the NHS you had to performance manage stuff ‘cos if you failed, you got sacked. So, you know, we’re saying, ‘right, we need long term, visionary targets’ and they’re saying, ‘well, how do we achieve that?’ I say, ‘I don’t know. Set the target, then decide how you’re going to do it or how do you performance manage it if you don’t know what you’re
going to do?’ They say, ‘we can’t performance manage something we haven’t invented yet’. Well - you should be setting that target.’ (EH manager ID40, site 11)

There were many frustrations expressed by LA officers about the practices and attitudes of colleagues from health services backgrounds; in terms of their willingness to assist with practical issues, their approach to risk and performance management, the lack of visible impacts arising from meetings and strategies, and also the cost of GPs. Conversely, others have described GP frustrations with LA colleagues, for example when HWB meetings were held on Fridays, which is a busy day for GP surgeries (Coleman, Checkland et al. 2014).

5.3 Issues with the public health transition
There were specific tensions arising from the transfer of PH medicine colleagues from the NHS to LAs, as summarised by an EH manager;

‘..unfortunately I think that the whole spectre of how public health will be transferred into Local Government has caused some barriers to be put up: Some serious concerns about cultural differences and whether they’ll be absorbed. Whether there will be savings. Whether they’ll be split up and spread to the four winds... Whether they are real or not, there are concerns of, is this a takeover bid. How are we going to fare in Local Government? We’ve got different cultures, how is that going to work? ‘ (EH manager ID34, site 7)

An EH practitioner was curious as to whether the transferred staff would retain their NHS attitudes and practices or adopt the working practices of LAs, which they felt was to fail to evaluate work;

‘I wonder whether the NHS mindset is going to be brought over to the Local Authority, or whether the Public Health People are going to come across to the Local Authority and be brainwashed into working the way the Local Authority does, which is without evaluation, really.’ (EH practitioner ID45, site 16)

This practitioner also pointed out the other ways in which they felt ways of working differed, particularly in that LA staff ‘just get on with it’;
'Local Authorities... you know, things change and the tide rises and people just rise with it, they just get on with it... They change the work terms and conditions and we just get on with it. We have a little bit of a moan in the office but nobody leaves and nobody resigns in horror, they just get on with it, and I don’t know how the NHS staff will feel when they come into Local Authority.. ’ (EH practitioner ID45, site 16)

There were also concerns early in the process about structural matters, and where PH would physically fit in LAs, for example whether they would report directly to the Chief Executive or to fellow directors. Whilst this was an issue that was being considered and different sites found different solutions, this did not appear to be a source of great disagreement in the case study sites, although EH manager ID34 at site 7 reported issues where the DPH was initially planned to be located in Adult Social Care, which they felt would have impacted on salaries and their ability to attract the best candidate for the post. Case study sites 3 and 4 both suffered from a DPH vacancy during part of the shadow stage and the HWB agendas were seen to develop significantly, with respect to the attention given to wider public health matters, following the appointments of these individuals.

In some areas it was felt that the roles of different people involved in the new PH system were not well understood;

‘..we’ve identified is that, we don’t really understand what each other does and it’s not that they don’t understand what environmental health does, I don’t really understand what some of these, you know, health and wellbeing network manager type roles do’ (EH manager ID35, site 8)

An EH manager described difficulties in working together to create a partnership of equals and was concerned about an imbalance in the relationship;

‘I mean the definition of a partnership is how to smile nicely at the other person, whilst working out how to spend their money and that’s what’s going on at the moment. They want us to do all their work. We’re saying we’re a partner, an equal partner, not your skivvies.’ (EH manager ID37, site 10)
One EH manager described addressing snobbery from PH colleagues, where the council was joked about by health service PH staff and seen as lower status;

‘...people tend to refer to the Council as the ‘Cooncil’ and ‘Cooncillors’, because ‘Cooncil’ is a bit more sort of common. Are you here for the ‘Cooncil’ yeah alreet and it’s a sort of stuff – it’s a putdown, and some of the staff were making that sort of joke when I was doing that presentation [to public health staff due to transfer to the LA]. And I said: Look I’ve got a hide like a rhinoceros but you say ‘Cooncil’ to a member of staff at the civic centre and you don’t know them as well as you know me... you’ll make an enemy for life...in a year’s time you’ll all be working for the ‘Cooncil’ and you won’t like people diminishing it like that,’ (EH manager ID40, site 11)

The same manager was concerned about the calibre of remaining PH staff, following an exodus following a time of flux and uncertainty;

‘[public health colleagues] they’ve got a lot of fears and a lot of the good people have left, so we’re left with the er, you know, people who haven’t been able to get a job,’ (EH manager ID40, site 11)

An EH academic also predicted power struggles as the new structures settled;

‘I think with the shake-up that’s happening now with reorganisation there will be a lot of professional power struggles going on, from the major issues to even the micro issues, about who’s going to get the top jobs in public health,’ (EH practitioner and academic ID42)

The majority of interviews took place during the shadow period of HWB development, which was a time of uncertainty and change. The quotations included in this section show complex feelings and expectations around PH transition, which formally took place on 1st April 2013. A useful and interesting research project would be to follow up to establish whether these concerns, particularly regarding assimilation of attitudes and practices, snobbery and calibre of staff have been realised.
5.4 Tensions between local authorities in two-tier systems
As I have described in chapter 2, sampling for this research included representatives from both unitary and two-tier LA areas. In many areas, the relationship between the tiers has been historically poor and the establishment of HWBs at the upper tier, whilst many services impacting on the social determinants of health sit in the lower tier, has in places exacerbated tensions. In some areas, there was a feeling that tensions were directly related to the historic context, where relationships were previously strained. Many interviewees described difficult relationships between the LA tiers;

‘... there’s definitely been a difficulty working with the county that they want to lead on things and we might talk about doing things together, but then it doesn’t happen, so there’s quite a bit of cynicism at district level about the way that the county behaves.’ (EH manager ID23, Site 1)

An EH manager reported a ‘Big Brother’ attitude at, the upper, county level;

‘I think there is a very dictatorial attitude from the County on this, I think it’s fair to say that the Districts and the County in [area] do not have a particularly rosy relationship.... it’s always been felt that they play Big Brother...they cannot engage at local level.’ (EH manager ID44, site 15)

Officers and elected members at district level expressed resentment at being instructed by the county, although they did not generally voice this feeling in public at the observed HWB meetings at case study sites;

‘I mean some of our district councillors...they hate it. It's just...who are they to tell us what to do?’ (HWB member ID9, site 2)

This was described by one HWB member as a ‘parent-child’ relationship, highlighting the differences in LA budgets;

‘..there is a tension, a healthy tension often, not just across the health and wellbeing board but across the whole range of issues between the districts and boroughs and the county and it is very much a parent-child attitude, though the districts and boroughs all hate that, and the budgets for the districts and boroughs are minuscule
An EH manager expressed concerns about how the disconnect between the tiers would affect funding for their services at district level;

‘But the problem will be of course, that they, at that level, will then not wish to secure any funding for our, at our local level stuff, because it doesn’t fit with their, at high level, priorities.’ (EH manager ID44, site 15)(my emphasis)

In a related comment, another EH manager was concerned that district functions were being overlooked at the county strategic level;

‘...when the county council have pulled some monitoring information together for the [joint health and wellbeing] strategy, they haven’t looked at any of those things that the Districts would deliver at all,’ (EH manager ID35, site 8)

Others described ‘ambivalence’ at county level towards the districts and highlighted issues with control of the interface, which was not straightforward;

‘.the other thing to just consider is the tension and the relationship between the county and the districts and, I think, that starts to show through and, I think, the county is a little bit ambivalent about how they involve districts, so, you’ll see some tension emerging between councillors, which isn’t very helpful, and different people thinking that they control the interface between,’ (HWB member ID20, site 1)

In contrast, a HWB member at the same site based at county level described the difficulties from the upper-tier perspective, highlighting concerns that the focus needed to be on strategic rather than operational issues;

‘How can we involve the districts and boroughs in a way that they feel included and that we can maximise their contribution, but at the same time make sure that we focus on the strategic stuff – some of their services are strategic too – but we
maintain a focus on the strategic stuff with a county-wide perspective, without getting bogged down in very local, operational issues, so that’s a tension to manage.’ (HWB member ID19, site 1)

Relationships between different LA tiers in many areas have been difficult historically, and these have come to the fore as districts attempt to highlight their PH roles in the new system, which could impact on future service funding. In some areas, there is a feeling that the county is acting in a ‘Big Brother role’ and the lower tier LA officers and elected members expressed resentment at this attitude. Although HWB structures are new in that elected members and officers sit as equals, tensions were not reported and neither were they seen during observations of meetings. Tensions between LA tiers relating to HWB structures and functions are described in chapter 4.

5.5 Consequences of conflicts and tensions
Some interviewees actively sought some disagreement, suggesting that relations were immature because people were ‘being quite nice to each other’;

‘I don’t think we’ve yet had the really challenging debates about alignment of priorities. I think we’re still at that stage of being quite nice to each other.’ (HWB member ID11, site 2)

Other interviewees also viewed feeling able to disagree as coming with knowledge of the other party, seeing conflict as a normal part of any healthy working relationship;

‘sometimes, I think, areas want all their partnerships to be really rosy, whereas, we do have quite a lot of conflict with some of our partners, but that just seemed to be any part of relationships… part of the strength of us here is being able to have that conversation and come to some sort of agreement.’ (HWB support officer ID30, site 4)

This view was supported by another HWB support officer who felt that a level of trust was needed to be able to disagree and to effectively make tough decisions;

‘The first period of any change has got to be about the relationships and the culture…what we have to do is learn to trust each other enough to be able to say I
don’t agree with it; and for the board to be able to go through some very difficult decommissioning decisions.’ (HWB support officer ID8, site 2)

Examples were given of different approaches to managing conflicts and tensions between the different parties, in one case taking a pragmatic approach by actively supporting some policies more than others;

‘If we go back four, five years ago, there probably wasn't the greatest relationships between the districts and the county. Everybody wasted energy and actually the people that suffer then are the public. So actually, we've all got to a stage that, oh for goodness sake, let's get on and find a pragmatic way of working in partnership... at times [we] say this isn't a priority for us. So we won’t derail it but actually we're not going to be right there at the front with the policy.’ (HWB support officer ID8, site 2)

Another interviewee suggested playing to the strengths of various organisations;

‘..my impression of a district council is that they’re very good delivery vehicles.. if you say here’s some money if you want to do this, it’ll get delivered and it’ll get done to a fairly good degree. A county council or quite large unitary metropolitan councils are quite good at strategy but they tend to probably start to struggle a bit with some of the delivery elements..’ (HWB member ID21, site 1)

Many interviewees felt that being able to disagree was a necessary part of a good working relationship: a healthy sign. However, being able to disagree on matters of policy and strategy in a context of mutual respect, is quite different from feeling belittled, dismissed or misunderstood, as several interviewees working in the new PH system clearly expressed.

5.6 The future
There were hopes that the future would bring improved working relationships, including an ability to have challenging comments better received in meetings;

‘..if you say something that's maybe not fitting in with the thinking of everybody else in the room, how people manage that and receive it in the way it's meant, rather
than being a bit dismissive or thinking you're being aggressive.’ (HWB member ID28, site 4)

An EH practitioner (ID38, site10) reported that whilst their PH colleagues were very different, there was a level of respect between them and they hoped for greater recognition; and an EH manager described the benefits of physically seating people from different groups together;

‘..you can write all the strategies you like, actually, it comes down to...we’ve been really impressed by physically co-locating people together, how they suddenly work better and, I think, that’s a really good model for public health going forward.’ (EH manager ID41, site 12)

Others, looking at the bigger picture, felt that the opportunities offered in the new system were significant and should not be overshadowed by ‘factionism’;

‘...the opportunities for cross boundary working, integration across different groups of people, but that also just in terms of geography and places..., that we can actually seize the opportunities rather than let any kind if factionism come between us because it really would be a waste of an opportunity’ (HWB member ID17, site 1)

Another HWB member with an LA background agreed, feeling that the new opportunity to work with GPs was a good one;

‘I think it’s very exciting and I’m sure it won’t be the first time it’s happened, but when these times occur, if you can grab hold of it, it could be very, very good news, and the introduction of doctors, definitely into the scheme, and if you like the health professionals generally, into the scheme, I think is extremely good news and if we can, if we can harness it, it will be very, very good altogether.’ (HWB member ID22, site 1)

There was positivity from many LA officers and elected members that good relationships could be developed in the new system, whether between individuals, occupational groups and organisations. There was also an enthusiasm from some interviewees to make the most
of the new working relationships, particularly between LAs and GPs, that the new system had put in place.

5.7 Conclusion

This chapter has focussed primarily on the story of misunderstandings, tensions and differences between the various players in the new English PH system, whether at personal, occupational or organisational levels, but this is not to say that positive and constructive relations did not exist and these are referred to throughout this thesis. Interviews were carried out in the context of LA HWBs and it was very difficult to recruit GPs, so the representation of their views is limited. Interestingly, the tensions expressed by individuals during interviews were rarely seen in public at HWB meetings, and at site 2 in particular it was evident that most discussion took place outside the meeting.

Many would argue that this tension is healthy and that honest exchanges are required for the new system to deliver. However, the ability to debate views in an atmosphere of mutual respect is quite different from working in an environment of snobbery or misunderstanding, as described by some interviewees.

There was a will, expressed by people from a variety of occupational backgrounds, to improve relationships and work more closely together for the members of the public they serve. Many felt that the new system offered new and exciting opportunities, particularly in the development of new working relationships between LAs (elected members and officers) and GPs.

It would be useful to carry out further research on the views of others in the system and on how relationships have developed now the system is live. The degree of tension between organisations and individuals clearly varied, but the majority of people interviewed and meetings observed included some degree of discord or frustration, whether historic, current or both.
Chapter summary

This chapter has focussed on the tensions between many of the different actors in the new public health system as they adapt to new organisational structures and ways of working. However, these tensions are seen by some as healthy, and there is an general enthusiasm to develop good working relationships for the benefit of local populations.

This chapter does not directly address any specific research question as the theme of tensions emerged during analysis of the data. Nevertheless, it does contribute towards answering question 1, as tensions were an underlying issue in local HWB development.
6 Interface between Health and Wellbeing Boards and Clinical Commissioning Groups

This chapter will explore how the historical context is seen; the interface currently between HWBs and CCGs in terms of relationships and attendance at meetings; the impact of the CCG authorisation process; influences on structures and functions; and finally considers what the future might hold.

As I have discussed in the literature review, the HSCA12 and its preceding White Papers introduced significant changes to the way in which healthcare (in the form of CCGs) and LAs work together. HWBs have both LA and CCG representatives as statutory members, and whereas there have been many previous attempts at joint working between healthcare and social care, the legal requirement for GPs and LAs to work together as a committee is new. It has been said that HWBs are ‘the only component of the new system with the potential to bring together different organisations and interests to promote local collaboration and integration’ (Coleman, Checkland et al. 2014). Interestingly, whilst CCG representatives statutorily form part of HWBs, LA HWB members do not automatically have a place on CCGs; and CCG members do not have places on other LA committees.

This research primarily took place during the ‘shadow’ stage of HWB development covering the year before they went live in April 2013. The focus was on HWBs and CCG representatives as members of HWBs and the findings reveal the complexities and tensions arising from statutory partnership building during a time of other organisational change and challenging deadlines.

Chapter 5 discussed relationship tensions between the different players in the new PH system in more depth.

6.1 Historical context

The role of history and its influence on current developments was mentioned by several interviewees, some highlighting the similarities between Primary Care Trusts (PCTs) and the CCGs which have replaced them;
‘I think, oh, I’m just being a bit of an old fart! You know, if you came into this new, you’d say, oh, how exciting, but when you’ve been around a bit, you think, there’s something familiar about this, and I chair the meeting with the CCG...we have regular meetings just to share where we’ve got to in the process, and they describe the structure and I just drop in, ‘oh, that sounds like a PCT, doesn’t it?’ And they all laugh! They’re not stupid. And they’re just thinking, ‘well, here we go again.’’ (EH manager ID41, site 12)(my emphasis)

Some felt that the new structures had the potential to improve upon the previous PCT arrangements but it was also noted by a HWB member that the CCG priorities locally were currently the same as the former PCTs, mainly due to time limitations;

‘If you look at the [PCT] cluster, commissioning priorities, intentions, most of the CCGs it’s acknowledged will adopt those for this year because they haven’t got time to do anything else really.’ (HWB member ID21, site 1)

In contrast, an EH manager felt that the historic constant reorganisation of the health service had led to a loss of focus, commitment and continuity and a recycling of the same staff in different roles which made joint working in the new system difficult;

‘..if they’re talking candidly.. they’ll say, well, you know, Governments want to constantly change the NHS to demonstrate that they’re doing something and they’re not that bothered about whether it improves the NHS, they just want to be seen to be doing things. So we recycle the same people and, you know, they pop up in other roles,...it’s hard to get commitment from any of them, because they’re not sure whether they’re going to be there in a year’s time, we’re not sure whether the commitments that we make are going to work, whether they’re going to be there, and experience tells us that they won’t.’ (EH manager ID41, site 12)

A LA officer HWB member reflected on historic tensions between LA and health service colleagues, (as I have discussed in chapter 1), and felt that the experience had been useful in recognising the investment needed to develop partnerships in the new system;
‘It would be difficult to see how you could make a Health and Wellbeing Board work without effective partnership relationships, and we were fortunate enough to have gone through some difficult times in our relationship with health, ... to act as a catalyst to us recognising the size of the investment we needed to make in growing those relationships.’ (HWB member ID19, site 1)

The new arrangements were often described in their historical context and Lewis (1999) notes that historical local relationships are important in determining (health and social care) outcomes. Interviewees were conscious of the role of history in a variety of ways; whether by noticing similarities with former structures and policies, or an awareness of the weaknesses of previous arrangements, or the loss of continuity, focus and commitment caused by constant health service reorganisation, or in recognising the investment needed to work successfully together in the future, including in managing short-term funding.

6.2 Health and Wellbeing Board relationships with Clinical Commissioning Groups

Several HWB support officers and members mentioned the need to ‘get the balance right’ between LA and CCG representation on their HWBs. One interviewee felt that their local CCG had not played a full role in the HWB shadow stage, due to the focus on establishing a new organisation, and hoped that once other more pressing priorities had been dealt with, the balance would even up;

‘..the CCGs have been very much a junior partner in this at the moment. And I think there is a very good reason for that, because this has been landed on them as a responsibility and they’ve got many other priorities around authorising their own Clinical Commissioning Groups... Once that’s out of the way I think we can see them playing a much stronger role in how this works and that’s what I really would like to see. I don’t want it to be seen as a [name] Council dominated thing.’

(HWB Support Officer, ID6, site 3) (my emphasis)

A HWB support officer also felt that building relationships with CCGs was made difficult by their changing management structures and representatives (ie lack of continuity), again
referring to authorisation as an issue. There also were some initial expectations from LA members that CCG representatives would be difficult to work with. A HWB member expressed pleasant surprise at the calibre of the GPs on the HWB, whilst revealing their more negative feelings about medical colleagues in general, although interactions observed at HWB meetings were generally cordial;

‘I share the same prejudice as everybody else, that... a lot of medical people think that because they’ve got a degree in medicine they have a right to rule the world effectively - I exaggerate to make the point. I think that was a little bit of the case here, but having said that, some of the GPs on the health and wellbeing board are very, very good. They’re civilised people, they’re intelligent, knowledgeable people, and they’re there for the right reasons.’ (HWB member ID27, site 4)

However, a HWB support officer at the same case study site expressed concerns at the knowledge and ability of CCG members to take on the management of large budgets and negotiate with powerful parties;

‘A challenge has been, again, the CCG’s knowledge. I have a lot of sympathy with them. You’ve got a group of GPs who are taking responsibility for, I think it works out just for [area] about £260million worth of services, which is as big as the council’s net budget, when...and these are people who’ve been used to dealing with...they may have had a practice, they may have had a couple of practices, so let’s say at best somebody might have got a bigger area, nearer half a million, £2million, and all of a sudden they’re responsible for something over... and they have to hold their own with some big players.’ (HWB support officer ID29, site 4)

As I have discussed in chapter 1, there are known significant differences between the world views and practices of LAs and the health service. A HWB support officer, who has worked in both LA and healthcare settings, described some of the differences between the organisations in the new system, from which misunderstandings had led to a heated exchange at a HWB meeting;

‘I’ve got to ask a lot more people now, and I’ve got to line up a lot more people and, you know, that’s really difficult and it takes a lot of time and a lot of effort and
a lot of shoe leather and I think even experienced people don’t get it right because there’s so many different people with different interests, it’s easy to miss people... there’s so many different agendas going around, it’s easier to cross one line when you don’t realise it and... I think GPs are particularly vulnerable because a lot of them have not been exposed to any of this type of thing before, they’ve been practitioners basically [and it’s] easy to fall foul of it and they did.’ (HWB support officer ID14, site 1)

Viewing the issues from an LA perspective, a HWB member felt that the use of technical language by GPs was a challenge when communicating with non-health lay people on the board;

‘..some politicians who have no experience will say why are you doing that like this, I don’t understand it, and when a professional is asked to account, they have to actually think, well, I’m doing it because of this, and they find it very difficult to use ordinary every day terms, not simple terms, ordinary everyday language, and some GPs haven’t got a clue, and you say I don’t understand what you’re saying, you’re using a lot of acronyms, you’re using technical...explain to me in simple terms..’.

(HWB member ID27, site 4)

There were also differences in the priorities between LAs and CCGs, with one interviewee feeling that CCGs focussed on local issues, rather than seeing their role as part of the wider PH community, and this fits with the findings of others who have reported that GPs involved with commissioning tend to struggle to take on board wider PH issues, tending instead to focus narrowly on services provided in general practice (Miller, Peckham et al. 2012);

‘I think there is a [CCG] focus on their small geographical areas, rather than seeing [area] as a sort of coherent and integrated system ..’ (HWB Support Officer ID6, site 3)

A further example was where a CCG wished to focus on the management of long term conditions, whereas others felt that children’s issues were of great importance;
'I think the challenge of making sure everybody’s aligned to the strategy, particularly the CCGs, and interestingly during the consultation on the JSNA and what should be seen as the big issues coming out of that there was quite a difference between the CCGs who saw things like long term conditions as being a priority, which others didn’t see as such a priority, and other people saw children as more of a priority, and you could see some of that reflects the CCGs’ needs to manage long term conditions, prevent people going into hospital, whereas they didn’t see children’s health issues as a big issue for them.’ (HWB member ID11, site 2)

Although CCGs are required to consult HWBs when drawing up their annual strategic plan, there are no powers to veto or amend them. Differences in priorities were identified by a HWB member as potential areas of conflict when making commissioning decisions (within the locally agreed health and wellbeing strategy) for the local population -there were concerns that the agreed priorities would not be followed through in practice by CCGs;

‘I do see areas of potential conflict... I think the role of the Health and Wellbeing Board is to identify need of the local population, prioritise that need and CCGs then need to commission accordingly, according to those priorities. If you think about what commissioning is, commissioning starts with identifying need, deciding priorities and specifying what needs to be done. So there is a danger that the Health and Wellbeing Board will do all that, and their expectations will be something different than what’s delivered by CCGs.’ (HWB member ID25, site 4)

As highlighted in the literature review, this is potentially important, as the new system contains within it no mechanism by which HWBs can compel CCGs to work within the JSNA or JHWBS. Should the CCG choose to focus upon other service areas, the most the HWB can do is require them to ‘provide an account’ as to why they have failed to follow the JSNA. Others have reported a disconnect between CCGs and HWBs in some areas, with a need for co-ownership of HWB and its strategies to overcome the lack of HWB powers in this area (Coleman, Checkland et al. 2014).
One case study site interviewee had recognised the potential difficulties posed by differences in world views and worked hard to overcome them from an early stage, feeling that this had been a good investment;

‘One of the things that we identified very early on..[is] the scale of the cultural challenge, because in the same way that we are new to the health world, actually the health world is new to local government, and recognising that for GPs in particular, it would be quite a challenge to understand and get to grips with how our system works... so we didn’t underestimate the scale of that challenge and just how much time and effort we’d have to put into fostering and building those relationships... We started doing the rounds of the lead practices, you know, to meet the new GPs, to start to talk to them about how we were going to work together; not just what we had to do, but how we wanted to work together, so we named the fact that we’ve got different cultures but we need to grow a new culture which is about the interface between the two sectors, and I think that was probably the best thing we ever did.’ (HWB member ID19, Site 1) (my emphasis)

Relationships between CCG representatives and their LA colleagues have developed under the pressure of statutory obligation at a time of upheaval and change. These groups have not generally worked closely together previously and there are significant differences in approaches, world view, language, funding streams, annual cycles and other pressures, which has made the period of transition more challenging in some areas. However, the research findings indicate there is a general willingness to work together to develop an effective interface and partnership between the organisations.

6.3 Clinical Commissioning Group representation on Health and Wellbeing Boards
Coleman et al (2014) have noted that the representation of CCGs on HWBs vary from GPs to managers and that there is a need for continuity in attendees, this was also true of these research findings. LA HWB members and support officers expressed concerns that the CCG representatives were not necessarily representative of their GP colleagues who make up the CCG membership, and that this could have an impact on the effectiveness of the HWB;
‘...there’s a lot of myths about what GPs are actually like and, I think, as well, because you’ve got GPs on the health and wellbeing board who are the leaders in their CCG’s, they’re not necessarily of the same mindset as the wider GP body. So the fact that we’ve got two incredibly talented, constructive people who are sitting at the health and wellbeing board who have a degree of management experience, that’s not necessarily...you’ve got to think about, well, how does the health and wellbeing board’s voice, if you like, extend to the wider GP body?’ (HWB Support Officer, ID12, site 2)(my emphasis)

Similarly, an EH manager had noted that locally there was a lack of GP support for their CCG representative, especially in the amount of time spent on strategic work;

‘.from his own GPs, they don’t actually get the strategic side. So he doesn’t get a lot of support from them. Even the GPs’ practices say why are you spending so much time on this?’ (EH manager ID40, site 11)

A HWB member shared concerns about GP representation and was unsure whether GPs as small business people could set aside their personal business interests;

‘..the CCGs are difficult. I think they’re going to be difficult and problematic. I’m not sure how one GP can represent so many. And I know they don’t like me saying this but, to me, I see them as a private sector in a sort of way, because they are actually. You know, they do run their own shows, you know, it’s rather like bums on seats, that’s where your money comes from. So they are in challenge to each other. And if one is decision making for a multitude, can he lay aside, he or she, can he lay aside his own personal interests in that way? I don’t know, I don’t think it’s always possible.’ (HWB member ID18, site 1)

An interviewee expressed also concern at GP personal interests influencing their strategic decisions; however the issue was not mentioned by others.

6.4 Clinical Comissioning Group authorisation as a distraction
As a complimentary research project (Warwick-Giles forthcoming), has also found the mandatory process of CCG authorisation was intensive and time-consuming. The findings
of this project indicate that the demands of authorisation often limited the ability of CCGs to play a full role in HWB development during the shadow stage;

‘The system’s been in flux... the CCGs who are a substantial part of the board membership are now heads down in authorisation and preparing to go live on the 1st of April. You’re not going to get anything sensible out of a network board system until the rest of the system is bedded down.’ (HWB Member ID7, site 3) (my emphasis)

This distraction proved difficult for some HWB support officers, as they were developing HWB structures and strategies with the focus of a significant part of the HWB membership being elsewhere, affecting the priority given to HWB matters. A HWB support officer also felt that the demands of authorisation (and other factors) were inhibiting CCGs from playing a full role in developing HWB strategies;

‘...as the board settles down and we get consistent attendance from the CCG... once they’ve appointed all their management team and the governance body, they’ve got a new chair, for example, so these are all relationships that will need to bed down, but, I think, once we get past the big hump of authorisation and public health formally transfers and we all know what our budgets are, I think, that’s when they can be a bit more strategic. ’ (HWB support officer ID30, site 4)(my emphasis)

This finding is supported by observational data and document analysis, where it was generally evident that the main CCG contribution to HWB agendas and meetings during the pre-shadow and shadow stages was to provide updates on the authorisation process. This was summed up by a HWB member, who nevertheless felt that the development of CCGs locally was an important issue for the HWB;

‘...the priorities we’ve had in recent months is actually the development of the role of GP practices, commissioning groups, that has been our absolute focus and dominated much of the agenda because that’s key for us.’ (HWB member ID27, site 4)
It appears that the authorisation process took much time and energy and was in many ways a distraction away from the development of HWB strategies and development for the CCG representatives. However, the need for CCGs to achieve authorisation was understood as essential by other HWB members and they were generally supportive in allowing it to dominate the CCG contributions of HWB agendas and meetings, hoping that they would be able to address strategic issues when things had ‘settled down’.

6.5 Clinical Commissioning Group attendance and participation in Health and Wellbeing Board meetings

Perhaps as a consequence of the demands of authorisation, some HWBs struggled with poor CCG attendance at their meetings. Others have noted that the frequency and timing of HWB meetings could be problematic for GPs (Coleman, Checkland et al. 2014). At one site, CCG attendance had been so poor that the LA had sent a letter requesting that the issue be addressed;

‘I have chivvied people up to try and come. We’ve written to the CCG in the past because at one stage we weren’t getting the representation and that improved, shall we say.’ (HWB support officer ID29, site 4)

A support officer at the same HWB expressed their surprise at the lack of CCG intention to attend HWB meetings during summer months;

‘...the GPs fully expected just to have a two month summer break from the meeting schedule, and lots of authorities do postpone committees over the summer period, but that’s not something that we’ve ever done and it was just the fact that, well, of course, we won’t be able to attend, because it is the summer! And I was quite surprised, because, I thought, people still get ill, I’m sure people still get ill, so I presume that you’re still working!’ (HWB support officer ID30, site 4)

The support officer went on to say that they had scheduled HWB meetings for convenient times for CCG members to try to improve their attendance;

‘...and the CCG, because of the time pressures, just won’t attend if they don’t think it’s going to add value to the day to day, so that’s part of why we arranged lunch
At a different case study HWB meeting, it had been suggested that members might plan an ‘away day’ to set their priorities for the coming year. This was not supported by CCG representatives, as explained by a HWB member, the value of GP time was a factor;

‘..it was interesting that [name], the CCG Chair for[area], wasn’t interested in putting time into a day to look at our priorities for the future and how we operate as a Board. Now on the one hand that suggests to me that he’s comfortable with the way things are. The other aspect is that GPs don’t want to give of their time freely, and that’s a very real fact, and the other thing is there’s a teensy bit of disappointment for me that they don’t think ...that’s worth doing. ’ (HWB member ID19, site 1)(my emphasis)

To put the above comment in context, GPs often have to book locum cover when they are away from their surgeries for meetings, which can be very expensive, however LA officer time also needs to be covered or work set aside. There are issues around perceptions of the value of the time of the different HWB members which illustrate their differing world views and willingness to see an investment of time and/ or money in the HWB as valuable.

One interviewee felt that the CCG reluctance to attend HWB meetings locally could be due to the attitudes and behaviour of elected members towards them at those meetings, although this behaviour was not seen during case study observations;

‘ The guy in charge of our CCG is very good, but when it comes to the Health and Wellbeing Board, he gets hammered by the councillors there, because of problems that their constituents are having getting access to surgeries. You know, my constituent trapped his thumb in a drawer and he couldn’t get to the surgery on a Saturday because it was shut. So you get the pitiful sort of  ‘here and now’ stuff getting debated – so he gets that and he tends not to come to the Health and Wellbeing Board.’ (EH manager ID40, site 11)(my emphasis)
Others noted that even when CCG attendance was good, they often made little contribution to the HWB meetings and this was noted in many of my observations. Some thought that this could be due to confusion about their role there;

‘I do wonder if the reason why the CCG people don’t say an awful lot [at HWB meetings] is because they’re unsure of how the Health and Wellbeing Board should work,’ (HWB member ID19, site 1)

One interviewee also felt that CCG colleagues were concerned about their skills in the new system;

‘...the CCGs are a bit worried .. they don’t feel they have the skills to do it’ (EH manager ID40, site 11)

The research observations and document analysis indicate that in some areas, CCG attendance at HWB meetings has been poor, and even where CCG members attend HWB meetings it has been noted their contribution has been limited to updates about the authorisation process. Various strategies have been tried to improve attendance, such as formally writing and scheduling meeting for convenient times. However, concerns remain that there is some confusion on the part of CCG members about their role and the skills to play this role at HWB meetings and that this could be inhibiting.

As I have noted earlier, in contrast to the statutory place for CCG members on HWBs, HWB members do not have a statutory place on CCGs; although it could be argued that the equivalent would be a place on other LA committees, interviewees did not appear to see it that way. One HWB member felt that the arrangements should be reciprocal, allowing elected members to fully represent their constituents in the new system;

‘I actually think that it’s very important for local members, district and borough members, to be represented on those CCG boards. I actually think that that’s a valuable use of time, because, you know, it’s actually about, what does this mean to the people you represent, who vote you in.’ (HWB member ID18, site 1)

It is unclear whether CCG meetings at case study sites were attended by LA PH representatives, as observing these meetings was outside the scope of this project, although
a strong PH presence in CCG meetings elsewhere has been noted by others (Warwick-Giles forthcoming).

6.6 Health and Wellbeing Board influence on Clinical Commissioning Group structures

There appeared to be differences in understanding between HWBs on their role in shaping CCG structures, with some feeling that it was their responsibility to influence, whereas others considered it to be a matter for the CCG. The most pressing areas of HWB concern and where they were trying to have influence appeared to be around CCG boundaries, with LAs preferring co-terminus boundaries. CCGs were required to have a statement of support from HWBs if they wished to cross LA boundaries, however this was not specifically mentioned by any interviewees in this research. Nevertheless, the literature indicates that working across multiple organisational boundaries where organisations are not co-terminous, have occupational differences, are regulated differently and have different financial regimes is difficult (Audit Commission 2009, Glasby, Dickinson et al. 2011).

A HWB support officer in an LA with three associated CCGs, one of which crosses another LA boundary, felt that a lack of central guidance on the issue had been unhelpful, in that even where there was a preference, the LA did not feel it could intervene;

‘People like the Local Authority very much had a ‘hands off – we’ll just let them get on with it’ approach. I think certainly talking to people in the Local Authority – I think their preferred solution would have been to have one. Certainly we’ve got no guidance regionally from the NHS, who also said: just hands off – just let them spontaneously do it.’ (HWB Support Officer ID6, site 3)

This support officer went on to say that they felt, in time, that the three CCGs would become one, but they also had little faith in the future of CCGs at all;

‘I should be very surprised if in five or ten years time we haven’t ended up with one thing – I don’t think CCGs will last that long. I’ll be surprised if they make it past two years...’ (HWB Support Officer, ID6, site 3)
Other HWBs felt that they had more of a role in influencing CCG structures and boundaries. At one case study site the LA successfully insisted that there was just one CCG in their area, effectively forcing two very different CCGs to merge. Observational data and document analysis for the site shows that the issue dominated the agendas of several HWB meetings. The concerns were described by the HWB support officer;

‘We had real concerns about what that meant for the services and equality of services across the borough given that two CCGs may have slightly different priorities, certainly would have commissioning rights, have the budget, and we were really bothered because they weren’t distinct geographical areas, they were just GPs who had elected across the board to go in either A or B CCG, so we had situations where in the same medical centre where there might be five practices you could legitimately have three of the GPs could be in one CCG and two in the other.’ (HWB support officer ID29, site 4)

Another HWB member at the site referred to government guidance suggesting that boundaries should be co-terminus, and that this had been a lever in securing the CCG merger;

‘There were tensions born out of the fact there were two groups of GP practices... and there were some tensions between them, because there’s a guidance of course from government saying we should have a single CCG on a single footprint. That’s the one we favoured... there were some difficulties initially there and at one stage it got pretty hairy, but at the end of the day, like the civilised people they are, they actually resolved those problems and now they have come together.’ (HWB member ID27, site 4)

The support officer for the same site also said that the merging of the two CCGs, whilst not easy, was a positive outcome and would simplify future working;

‘...they had to take a decision- what is going to be our line? And once that was agreed, they had to stick to it, I think. There is something there about lots of the partners around the table understanding that we have got the conviction to follow
This contrasts with the three very different CCGs which developed in the case study site which took a ‘hands off’ approach, as described by the HWB support officer;

‘These are new organisations with little or no guidance about how they should come together and what they should look like. If you look at our three CCGs – they’re such different models and that’s what happens when you ... ask people to spontaneously come together... whether they reflect any identifiable geography is such an odd thing to look at’. (HWB Support Officer ID6, site 3)

These findings show that there were different understandings of the central government position on the role of HWBs in shaping CCG structures and the need (or not) for co-terminus boundaries. This could be due to the rapidly changing policy situation at the pre-shadow and shadow stages and the HWB development at these stages. To contrast these two case study sites, one HWB went live with one co-terminus CCG and the other site went live with three CCGs, one of which crossed a neighbouring LA boundary. Following up on these case study sites now that they have entered the live phase would be a fruitful area for future research, exploring how the dynamics of the different CCGs and their HWBs develop over time.

6.7 Future possibilities
In general, despite some difficulties in the early stages, there was a feeling of optimism expressed by interviewees about working effectively with colleagues from different organisations in the future. A HWB member felt that understanding and respect were growing and that this boded well for commissioning decisions in the future;

‘I think we understand where they’re coming from; they understand where we’re coming from. We understand where the common ground is and we’re trying to develop that common ground, which is good. And respect’s growing as well. They begin to respect us. We’re no longer written off simply as pen pushers and bureaucrats, which was a temptation to do that, and we’re beginning to realise I suppose in a way that although they may be GPs, some of those GPs can be very
effective and good managers and can develop a complete service where they can actually commission healthcare properly and manage it and administer it properly.’

(HWB member ID27, site 4)

A HWB support officer also agreed that CCG and LA understanding the impact they could jointly have on the wider determinants of health, such as housing, was a real achievement for their local population;

‘..and then there's this light bulb moment, and we'd been talking...one of the datasets that highlighted a big issue across the whole of the county, saying the county needs more affordable housing; you know, like 4,000 affordable houses a year to be built across the county... and the chair, he was just sitting there and he said, this isn't about my CCG, this is about us influencing those people over there to build 4,000 affordable houses a year. That's what we've got to do. And you just think right... I mean, it was just butterflies inside your stomach.’ (HWB support officer ID8, site 2)

Others expressed some optimism, in spite of initial misgivings, along with a commitment to make the best of the situation, and a HWB member expressed the feeling that the new partnership opportunity (offered by the HWB) between LAs and the health service could be very powerful and might lead to a better system than the former one;

‘It’s a powerful force so to have clinicians, supported by politicians, you know, and if it works, well, it’s got a better chance of working than any other system we’ve had.’ (HWB member ID25, site 4)

6.8 Conclusion
HWBs and CCGs are now statutorily required to work together, and generally this has required new relationships and partnerships to be built during a time of upheaval and change and where there were competing pressures, such as authorisation deadlines. These pressures have in some areas proved restrictive on the level of commitment of time and attention given to HWB strategy development by CCG members, however there are hopes that this will change as the system ‘settles down.’ There was some confusion around the
role of the HWB in influencing CCG structures and on the possible role of HWB members on CCGs.

There are indications that investment in building partnerships is starting to bear fruit in terms of increased mutual understanding and commitment, where previously there was a level of mistrust and lack of engagement in some areas. However it remains to be seen whether these new partnerships will result in better health outcomes than previous partnership initiatives. There also remain some concerns at the ability of some CCGs to play a full role in the new system, in managing their new and very large budgets, and in agreeing priorities at HWB level and following these through in commissioning decisions.

The statutory partnership-building experience in many areas has not been smooth and straightforward, and as one HWB support officer describes their feelings on the shadow phase;

‘...it’s been an interesting exercise in seeing if people can spontaneously create locally useful organisations and I wouldn’t want to see this happen again.’ (HWB Support Officer ID6, site 3)

Given the references to continuous restructures in the historic context part of this chapter, this support officer’s wish might not be fulfilled.

**Chapter summary**

HWBs mandated a new form of statutory partnership building between healthcare (CCGs) and LAs and demands of CCG authorisation limited their commitment to HWB development in some areas. However, there is some evidence that improved relationships and mutual understanding are seen as one of the early successes of HWBs.

This chapter addresses question 1 in that it identifies how HWBs were developing locally, in particular noting the underlying issues in the interface with CCGs.
7 Health inequalities conceptualisation: espousing and enacting

As the ancient authors of the epic poem Beowulf noted 'Anyone with gumption and a sharp mind will take the measure of two things: what's said and what's done.' (Heaney 1999:11). This observation remains relevant today and this chapter explores the differences between what HWB members, support officers, EH practitioners and managers say or ‘espouse’ about health inequalities, and what they actually propose to do or ‘enact’ in practice.

During interviews, people were asked about their understanding of health inequalities and what they felt could be done about them locally and during observations of HWB meetings any reference to health inequalities was highlighted in my fieldnotes. In addition, joint health and wellbeing strategies (JHWBS) were read and the content compared to that espoused by HWB members and other interviewees. Where the opportunity arose, local differences between espousing and enacting on health inequalities were discussed with interviewees. For the purposes of this chapter, ‘enactment’ is used to refer to strategies for action.

As I have explained in chapter 1, much of this research took place prior to HWBs going ‘live’ in April 2013, and as a consequence, interviewees were generally very keen to explain their hopes and expectations for their HWBs and in particular around health inequalities locally, as it was not possible for the effects of strategies to be discussed at that early stage.

Four illustrative areas have been chosen for comparison; the role of Marmot, prioritisation, differences in understanding, and the role of environmental health (EH). These areas were chosen as they were key themes in the research findings. Finally, ideas and comments on how the success of HWB work in tackling health inequalities could be measured are discussed. There were both similarities and differences in the understandings and priorities espoused by individuals and subsequently enacted by HWBs as priorities in their strategies. There were also mixed feelings about whether the enactment of HWB policies in practice would make any difference to health inequalities locally, as a HWB support officer candidly said;
'Addressing health inequalities is bloody difficult. My personal view is I kind of question whether specific actions even make any difference to health inequalities, when you’re looking at such a grand scale. You know, half a million people... the kind of macro-economics, it’s like a drop in the ocean basically. You try and do all this kind of community stuff and get people to go to their screenings, and then unemployment doubles and all the work is washed away within six months.’ (HWB support officer ID14, site 1)

Most other interviewees were more positive about potential impacts, however many examples given focussed on very limited or tightly defined issues.

7.1 Marmot
The literature review sets out the content and relevance of the ‘Fair Society, Healthy Lives’ report on health inequalities (Marmot 2010), otherwise known as the ‘Marmot Review’ and its impact on the policy documents and legislation that resulted in the formation and expected role of HWBs. The common theme noted at all case study sites was the acknowledgement of Marmot policy objectives or principles, although some were more overt than others, and some suggested that other frameworks could be also be useful. The following comment from a support officer explained the value of the principles as a framework in early stage prioritisation at a site where commitment to Marmot was proudly promoted;

‘... all Marmot did was help us to set priorities, it’s just a framework, you can choose any other framework if you want, they’re all, kind of, saying the same thing. We’re very clear, children, years 0-5 very important, preventative agenda and getting that right, mental health, huge issue in [area], hidden communities, massive issue in [area] and then the long term conditions, cardio respiratory problems and linking into that, diabetes, smoking, obesity and all the rest of it, so you can feed out from them and, so, the point is, actually, I don’t think we’re going to argue over
those priority areas, which is where I think Marmot took us to.’ (HWB support officer ID5, site 3)

A CCG HWB member at the same site agreed that Marmot had provided a useful framework for agreement at an early stage;

‘I think, Marmot resonates with me, as a GP, because it looks at all the life stages and that’s fine, but it’s only telling me what I knew already, so it’s good to be reassured by that, but I’m not hung up about whether it’s Marmot, or any other framework they use. I want to use a framework that everyone agrees on, initially, and can stick to and says, fine, let’s go forward with this, it doesn’t give us the answers, it just highlights the issues and where we ought to start’ (HWB member ID5, site 3)

Marmot was also subscribed to by many of the EH practitioners and managers interviewed;

‘To me, health inequalities is about having different health outcomes as a result of where you are born, or who you are born to, basically, and it’s about unfairness and having your life cut short just because your parents weren’t middle class or above and there is a gradient, so it’s not just that poor people die earlier, it’s that if the poorest people die the earliest and the middle poorest die the middle of that – so the social gradient that Marmot identified really, yeah, I really subscribe to that, definitely.’ (EH practitioner ID45, site 16)

An EH manager explained the reasons for the focus on Marmot in local policies and strategies, namely that it provided a point of focus at the right time;

‘I think it also came out at the same time and it was the flavour of the moment and it was a good way to go, it gave everybody a direction and something to hang on to.’ (EH manager ID48, site 19)
An EH manager at a different site added that the lack of other available guidance had led to their focus on Marmot when writing local policies and strategies;

‘...at the time, this was written before the public outcomes framework came into being, so the only thing we’d got to base it on really was Marmot.’ (EH manager ID4, site 3)

Another EH manager at the same case study site, explained the influence of Marmot in strategic planning at the LA, although interestingly ‘dying well’ was not a Marmot priority but had been included by the site in the draft JHWBS at the suggestion of the then DPH (however consultation responses on this inclusion were later found to be mixed and it is unclear whether it was retained following the appointment of a new DPH);

‘...each of the local authority reps have got a lead for one of the outcome themes of Marmot and ... we’re trying to join it all up at the moment... trying to join the dots, cause there’s lots of dots so you’ve got a health protection strategy, health inequalities strategy, there’s about 5 or 6 that’s all thematic. So what we’re trying to do is link those to the Marmot outcomes and actually match that to the lifecycle, so that you know you know, you get born in a healthy way, you die with dignity...’ (EH manager ID3, site 3)

In contrast to the enthusiasm seen at the above site, an EH practitioner with a national role explained their concerns about Marmot being seen as a ‘panacea’;

‘ these panaceas really worry me, I wish they were true. I wish somebody would give us the panacea, and we just go out and do it, but there’s been plenty of opportunities in the past and they haven’t worked yet.’ (EH practitioner with national role ID33)

They went on to talk about their concerns about how the Marmot principles could be adopted at a practical level to make a difference, and voiced their disappointment at the failure of central government to adopt the policy objective relating to poverty to ‘ensure a healthy standard of living for all’ (Marmot 2010 :116)
‘.. and then Marmot comes along, with all that reinforcement about reading at bedtime and stuff and yeah, I’m sure it all counts. But again, if I’m just sitting there in my scruffy flat, with not enough to eat and up to my neck in debt and being abused, you know, by society and partners and everything am I really in a frame of mind to be told the best thing I can do is read to my kids or is that the practical level at which we need to start and say, actually we can’t do anything about your housing at the moment, alright, and you are going to be poor for the foreseeable future, but these are things you can do and I don’t know which way we go on all that.. but we’d better sort it out because it’s no good trying to do everything and failing at so much, we need some successes ...Marmot’s important, yes. The bit of Marmot I’m most interested in, the bit the government hasn’t signed up to was poverty.’ (EH practitioner with national role ID33)(my emphasis)

It can be seen that Marmot was popularly adopted as a framework, but that some interviewees felt that this was more a matter of timing and an absence of alternatives, rather than a deep commitment to the policy objectives compared to other possible frameworks. There was some concern (although this was a minority view) that Marmot policy objectives may lead to unrealistic expectations and might not be readily applicable at a practical level.

In looking at enacting in relation to Marmot, it is useful to start with case study site 3 which was very committed to the Marmot policy objectives and had set up an operational group of high-level individuals devoted to the implementation of the Marmot principles locally. This was described by an interviewee;

‘...they’re basically the operational arm of the Health and Wellbeing Board, that’s my interpretation of it, so if there’s any actions from the Health and Wellbeing Board it goes to them.’ (EH manager ID1, site 3)

The interviewee went on to say that the group members felt that they would have a role in shaping the HWB. Structural and constitutional matters were discussed in chapter 4.
At case study site 1, the selecting of priorities for the JHWBS was very much the work of the PH team, and this was disappointing to a CCG member of the HWB, who felt they should have been consulted on the adoption of the lifecourse approach (as advocated by Marmot), but was nevertheless willing to implement the strategy in their CCG policies;

‘...and it just would have been helpful to say: do you want to take the life course approach, do you want to have focus on children and elderly? And then in fact, I think what they came up with was really good and it is things that we can easily pin health priorities to but I just, I personally don’t feel as a Member of the Health and Wellbeing Board, that we would have particular ownership of either really, although I’m happy to pick it up and run with it and that’s what we have to do, but I just think we could have shared in the understanding much more effectively..’
(HWB member ID17, site 1)

It can be seen that Marmot policy objectives have played a large role in influencing approaches to tackling health inequalities, particularly being seen as a useful starting framework for discussion.

7.2 Prioritising
The influence of Marmot, where two policy objectives relate specifically to children and young people, can be seen in the prioritisation of children as a population group in the developing strategies, by interviewees of different backgrounds. A commitment to prevention and addressing the social determinants of health was very much in evidence during the majority of interviews, although observations at all case study sites noted a focus on healthcare and social care during many HWB meetings, particularly at the CCG authorisation stage. Many agendas had authorisation as a standing item for some time and integrated care was also a regular feature on the agenda at meetings across the case study sites. It appeared that there were two approaches to issue-based prioritisation; focussing on specific population groups, such as children or vulnerable people; and focussing on health issues, such as smoking, drugs and alcohol, dementia or obesity. Sites generally adopted a mixture of both issue-based approaches and as I describe later, there was little real support
seen for geographical prioritisation other than in primary care, where the provision and quality of care were sometimes referred to as issues.

There was a great deal of support for a focus on children from members of HWBs with a variety of backgrounds, elected members and officers;

‘..for me, the children’s directorate has a tremendous role in the health and wellbeing board. Now, one of the frustrations I had initially was it was all about adults and older people and so, I firmly, in my CCG, have put resource and energy into getting the right people around the children’s agenda, because, for me, that links very strongly with the preventative agenda and if we get that right, we often pick up lots of other things, dysfunctional family units, mental health issues, drug and alcohol problems, so, you know, it all, kind of, links together really, but I feel quite strongly that we mustn’t lose the children’s agenda...[it shouldn’t be] playing second fiddle to anything, it should actually drive a lot of the other things.’ (HWB member ID5, site 3)

An EH manager described a local focus on education, children, older people and obesity, which whilst not being explicitly labelled as tackling health inequalities were likely to have an impact;

‘...that first meeting was quite driven towards education in children, which is fine and not an incorrect priority, but we need to be a bit wider than that. And health inequalities do play into that. ... so, I think rather than saying our local health and wellbeing board has picked out health inequalities as a key area, I don’t think they have, but I think that, the thinking is actually we need to look at education in children, a little bit about older people as well, and obesity. Health inequalities are actually fundamental to those. So it’s almost the other way around, we’re not saying we haven’t, but actually we’re focusing on these areas and health inequalities is a fundamental part of them.’ (EH manager ID47, site 18)

An interviewee with a PH role felt that alcohol, particularly in relation to young people was the most pressing issue locally;
‘Alcohol is our biggest challenge I would say. We’re something like the [number]th highest nationally for under 18 admissions for alcohol. Right up there as well for adults as well. Huge impact. Huge culture of drinking being the norm and not seen as a problem. So in terms of health priorities that’s absolutely mine.’ (HWB member ID26, site 4)

An HWB elected member at the same site with both a health service and LA background felt that raising expectations by focussing on education was important, with a message of individual empowerment;

‘...the underlying cause, in my view, not the expert’s view, not Public Health’s view, my personal view is it’s around lack of expectations. Absolutely, so people don’t strive education-wise, what’s it all about? My Mum’s never worked – my father’s never worked, you know, my brother doesn’t work, this is what’s meant for me in life... So there’s a big, huge task of trying to empower people to say: No. I can do better. I’m going to choose a different pathway. ... So you know, in many ways it does start with education then doesn’t it?’ (HWB member ID25, site 4)

A member of a HWB with a PH role felt that there was a risk that their department could dominate, with other voices being unheard;

*I think there’s a risk that it’s going to be too public health focused. I mean I could fill the board agenda ... But we need to support those other agencies to say it’s your board as well and you’re not just here to listen to what’s going on in public health, you’re here to bring your partnerships in.’ (HWB member ID26, site 4)

As we have seen, there was generally a focus on an issue-based approach to prioritisation rather than on geographical areas. There was no overt disagreement seen about this approach to prioritisation, although some interviewees did note that CCG representatives were often focussed on their geographical areas rather than the ‘bigger picture’. This was interesting, as there were many voices advocating many priorities and it appeared that the issue-based approach facilitated an agreed strategic direction. The rationale was explained by a HWB member;
'Now, on a strategic basis, something like [area] quite clearly you’ve got more affluent people with loads more money who can drink loads more red wine and get liver disease down in the south. Then you go to [area] where you drink strong larger and smoke yourself to death or go and nick cars or whatever. So therefore people have a different perception of what they mean by inequalities and how that’s presented...I’ve always had this belief.. that actually if you identify an issue, say, alcohol, it is alcohol we’re going to tackle and it doesn’t matter where you live. ... So let’s look at the illness and let’s tackle the illness. Don’t do it on a geographical scale.’ (HWB member ID21, site 1)

An EH manager in a very rural lower-tier authority felt it was important that local decisions were made on issue-based prioritisation, noting that child obesity was an issue in some areas of the county, but not in their district;

‘...child obesity is not a big problem here, because we’re a very old district ... inequalities for us are around older people. The inequalities for us, is real, is very, very real, about access to services because... there is no rural transport.’ (EH manager ID44, site 15)

Not all interviewees were so clear on what should be prioritised. One elected member of a HWB, expressed uncertainty in what should be done to tackle health inequalities;

‘What more can [LA] do to help [DPH] and CCGs in driving down health inequalities? I mean we all know what they are, you know, we live 10 years shorter in [area] than we do in [area] and you know, teenage pregnancies, obesity, it’s all worse in the North than it is in the South... think we’ve got to see what we can do about [it], I’m not sure we actually know.’ (HWB member ID9, site 2)(my emphasis)

There were other (non-issue based) approaches to prioritisation mentioned by some interviewees. A CCG member of a HWB felt that much could be done to address variation in primary care;
‘If you get big variations in primary care that’s another form of inequality and that’s something we can do easily at the CCG because we have access to that data. the other thing I should pick up is that with practices you’ve got to register the population but what the CCG has responsibility for is the whole population, including unregistered individuals.’ (HWB member ID17, site 1)

An EH manager felt that it was the quality of life rather than the length of life which should be the focus and priority in tackling health inequalities;

‘So what we are doing is making people live longer, but we’re making them live longer with illnesses and disabilities, and that is a difficulty for their life. So in terms of health inequality, our role, I feel, is, is to narrow the gap between illness and death... if you die at ninety, but you act like a thirty year old, well then you’ve done your business. And to have a massive terminal drop, so you know, you’ve got fitness, fitness, fitness – dmp! – as opposed to that gradual decline into old age, and that is, from my point of view, is what health inequality is about.’ (EH manager ID37, site 10)

A CCG member of a HWB was keen that their local population focus, particularly in relation to vulnerable groups was not lost;

‘.. you know when we talked initially about what the whole of the county looks like, that’s the Health and Wellbeing board role, for my patch ...it’s about that population and practice at an individual level and vulnerable groups level.’ (HWB member ID17, site 1)

A HWB member representing the voluntary sector was concerned about the impact of external policy decisions, feeling that the welfare system changes would make tackling health inequalities much more difficult;

‘..so actually we’re just going to make health inequalities worse with welfare benefit reform, with all of the things that people are facing...We’re about to enter into a whole new era I think of not that far from Dickensian England. And that’s the
worrying thing, because actually you're just compounding issues for people, aren't you?’ (HWB member ID28, site 4)

An EH practitioner took an even wider view saying that they considered that health inequalities were caused by much larger issues than the HWB could act on locally;

‘...what I believe will have the most fundamental effect on it obviously is reducing poverty and reducing the gradient difference between being poor and being rich in this country.... So unfortunately our economic philosophy doesn’t really work with that. So being a capitalist society ... you get the worst gradient. So it’s really to do with economics, war, housing, education, all these big things...’ (EH practitioner ID45, site 16)

Some context sites showed a lesser commitment to tackling health inequalities than the case study sites. In contrast to the majority of other sites, an EH manager at a context site explained that the existing strategies did not include priorities relating to the social determinants of health, but that this was based on previous initiatives and likely to change as they are reviewed;

‘...when you go back to the JSNA, those wider determinants aren’t really in there, it’s very much around the legacy of what was the local area agreement and the [area] Strategic Partnership and the priorities that were there got carried over and the strategy, you know, everybody will admit, was put together in a hurry really, so that the board had something to work to and could launch and that was it, but they’ve also recognised that in the next 12 months, we do need to refresh that...’ (EH manager ID35, site 8)

The only example where health inequalities appeared to be entirely lacking from the agenda was described by an EH manager working in a two-tier system, where the lower tier appeared to be largely unengaged;
'I don’t think they’ve picked up the word ‘inequalities’. I think what they’ve picked up here, and I don’t think they’re looking at it on an equality basis, I mean, for me, we have this huge equality agenda about gender, race, sexuality, whatever it is, we’ve got a huge agenda about that, but we have no equality agenda about health inequality and there’s inequality of provision here, because everyone’s got to go thirty miles to the nearest hospital..’ (EH manager ID44, site 15)

However, an EH practitioner at another authority also described how health inequalities was being treated as low priority;

‘.they’ve seen the word ‘inequalities’ and given it to our Social Inclusion Team to deal with and they’ve missed off the health, which obviously would be us, so it’s been given, the Health Inequalities Plan has been given to a fairly junior member of the Inequalities Team to write. I don’t think it’s seen as particularly important...’ (EH practitioner ID45, site 16)

It can be seen that the most commonly espoused prioritisation approach for tackling health inequalities was issue-focussed, with an emphasis on children and young people and including the social determinants of health. However, at some context sites there were reports of health inequalities being seen as low priority or as in one case being unacknowledged, and there are some concerns that health inequalities are caused by factors beyond the control of HWBs.

There were some indications that the espoused prioritisation of prevention and focus on the social determinants of health were starting to result in changes in local arrangements. An elected member of a HWB described what they felt was an achievement facilitated by the new system in securing a shift in funding towards upstream interventions;

‘So very pleased in the early stages that we managed to get £1million from the health budget here to give to district councils to do more of that work, which is an early sign that the health sector, now it's free from national targets, can see the bigger picture. Because the one thing I knew when I was chairing a PCT, unless you
start to tackle prevention, which is about lifestyle, it’s about diet, it’s about exercise, unless you start to tackle that at the front end over time, and it might be 30, 40 years, the service simply won’t be able to cope with what they need to do in terms of treating people. But the challenge then was to take some money from the back end, in other words stop treating people, and start [to] prevent... It can’t be just about treating ill people. But it never had the chance, I don’t think, under the old regime, to have a proper prevention agenda.’ (HWB member ID10, site 2)

They went on to give examples of prevention initiatives taking place locally;

‘...libraries and health. What’s that got to do with health? A bloody lot to do with health. For recovering mental health patients to be able to just go to a library and sit before a computer and engage themselves in interesting things... I was at the opening of an extended allotment yesterday in my patch. The contribution that makes to wellbeing is enormous. Healthy food, exercise, it’s a social group, they have raffles and cups of tea and buns and burgers. Again, this wellbeing thing has made a huge difference.’ (HWB member ID10, site 2)

An elected member of a different HWB agreed that the focus was now on prevention;

‘Prevention becomes the star.. you start thinking about things like this when you get the job.. but it did strike me that the most valuable thing you can give to anybody is good health.  Because you don’t realise how valuable it is, until you are poorly.’ (HWB member ID22, Site 1)

An interviewee from the voluntary sector felt that that service delivery in their area needed to radically change, if health inequalities were to be tackled locally and the impact was to be felt by the most deprived people. They also described some achievements already made;

‘.. what do you do about it? I don't know. I think I struggle a little bit with this whole... fairly well-off, middle class people sitting around a strategic meeting talking about the lives and ill-health of those that are not around the table....and I think unless we really, really radically look at the way services are delivered, we’re never really going to even touch that. If you think about [area] it's had enormous
investment and we have made some differences. So we’ve got nearer the regional and nearer the England average, but that’s not change for people in those worse deprived places. And that’s the issue, isn’t it?’ (HWB member ID28, site 4)

A HWB support officer was concerned that expectations on achieving improvements in health inequalities should be managed, but that it was possible progress could be made in very specific areas;

‘I think health inequalities is an important focus, and that it is a right thing to be doing, a worthy thing even. I think we need to manage our own expectations and everybody else’s expectations that in three years time everybody in [area] will live for the same amount of time. Because that won’t happen. But for the very specific, the more specific things we’ve done perhaps we can make progress. (HWB support officer ID14, site 1)

A HWB member at the same site recognised the need to be specific, saying that they felt the JHWBS was too wide and needed to be refined to have more meaning and practical effect;

‘..I would hope that the strategy is more internalised and you start seeing it quoted and reflected in individual agency work and, personally, I think, at the moment it’s broad enough to mean pretty much what you want it to mean, so that’s okay as a first stab at it, I think, we will need to get sharper and tighter in future years. ... (HWB member ID20, site 1)

An EH practitioner with an academic role was concerned that victim blaming (as seen in the media in relation to welfare changes, described earlier) could take place. They noted that difficult issues relating to the social determinants of health might be avoided in practice, such as the condition of private sector housing;

‘I think again we are at risk of the lifestyle issues, taking precedence and the sort of victim blaming, you know, stop smoking, lose weight these sort of diet, sexually transmitted disease type things, rather than the bigger, structural determinants,
which obviously are much trickier to get into with also conflicting policies - on the one hand, governments favouring the private rented sector, whilst they know that it’s got the worst housing stock and on the other hand, what are they going to do about it?’ (EH practitioner with academic role ID42)

A HWB member with a PH role described how there was a general consensus on the main issues in their area, although there were likely to be differences in opinion on practical priorities;

‘I think there is a broad agreement on the issues that affect [area]... that doesn’t mean they agree on everything on how it should be tackled...’ (HWB member ID15, site 1)

A HWB support officer described the practical difficulties in funding the prioritisation of preventative services;

‘... I’m sure there’s a balance that can be tipped towards the prevention side and that’ll bring you down to one of the thorniest challenges, who pays for it? Because if you look at prevention, you’re doing prevention to stop the demand on services further down the line, but with health it’s not like well, we do this, they don’t need that service tomorrow, it might be X number of years, which then saves somebody else the money, so will that somebody else invest money? So CCGs, will they invest money and how much will they want to put extra into prevention rather than treatment? And they then say our hands are tied because the hospitals take all our money so we’ve got nothing to put in. But we’ll get round it.’ (HWB support officer ID29, site 4)

An EH manager in a lower-tier authority with a large elderly population expressed concern that the omission of an important social determinant of health in county level strategy documents would lead to a loss of service funding in the future;

‘We felt the two big omissions from their considered emerging priorities, were nothing about activity...it was barely even mentioned in their obesity agenda, it was all about food and dietary stuff, rather than activity. But of course for us, with
older people, it’s all about activity. The longer you keep them active, the less likely they are to go into care, the less likely they are to have mental health problems and all the rest of it. We’re spending one and a half million quid a year out of a fourteen million quid net budget, on direct leisure provision. So it’s big for us. ... our fear of course, is that that will then mean that there will be no funding towards any activity provision in the future.’ (EH manager ID44, site 15)

When writing the JHWBS a HWB member with a PH role said that it was important that priorities were practical to have some meaning and impact;

‘...the health and wellbeing strategies are new, there isn’t a template, when we got together as a group there was a wide range of views as to what it should say and how it should say it, what it should talk about, because there’s no point in having a series of pious platitudes, it needs to be things that in some way the health and wellbeing board can influence.’ (HWB member ID15, site 1)(my emphasis)

Interestingly, although Marmot was mentioned by a large number of interviewees as being important, ‘ensure a healthy standard of living for all’, the priority not supported by central government also fell away in enactment at strategic level locally, perhaps because the tools available to address the issue at this level are very limited.

7.3 Differences in understanding

Having stated that there was a fairly common espoused approach to prioritisation, there was a notable difference in the perception and understanding of health inequalities between some HWB members with health service and LA backgrounds. This is neatly summed up by an EH manager at a case study site;

‘I think one of the problems is, is the definition of what health inequalities is. I think local authorities see it as the wider determinants, the NHS see it as something else.’ (EH manager ID1, site 3)

A HWB support officer at the same site elaborated, with the feeling that GPs were focussed on their local sphere of influence;
‘...one of the issues I would say with the GPs is whether they have a full understanding of the range of issues across [area] – or whether they have an understanding of the health inequalities that are implicit in their small area of [county].’ (HWB support officer ID6, site 3)

The perceptions of the above interviewees are very interesting in that they contrast with the understanding of health inequalities espoused by a CCG member of their HWB, who is quoted above as supporting the role of children’s service as a priority (ID5, site 3, see p142). The same site was the most vocal in its support of the Marmot principles, and perhaps adopting this approach allowed common priorities to be agreed between parties with varying understandings, and may also help lead to a common understanding over time.

An EH manager at a different site felt that the new system would change the appreciation of CCG representatives of the wider determinants of health;

‘They’ll just be thinking of immediate clinical care type things, rather than things like increasing employment opportunities and local economy. The real main reasons – poverty - that causes ill health. They won’t be thinking like that and that’s what this process will be trying to engender.’ (EH manager ID32, site 5)

There was also a feeling that LAs did not always appreciate the role that health service colleagues could have in tackling health inequalities locally, and that priorities need to be balanced;

‘We had a national support team visit ...and ... they... gave us a bit a reality check and said, it’s really great that you’re encouraging schools to make sure children get lots of activity and eat five a day, but you’ve still got people in their early 60’s who are going to have a heart attack or a stroke, who are going to die too soon, so you have to balance those long term interventions against making sure every GP is prescribing consistently, making sure all your practices know about all the right guidelines and they’re doing their blood pressure checks and all those things that, I think, at that point, the Local Authority hadn’t really grasped that we could influence that.’ (HWB Support Officer ID30, site 4)
A HWB member with a social care background described how they felt tackling health inequalities would look to them;

‘..for us, it would be represented by our commitment to things, like, maximising independence and reablement processes that give people the best possible quality of life.’ (HWB member ID20, site 1)

An EH manager described the drafting of a health inequalities plan by a healthcare colleague, which focussed only on healthcare;

‘..an NHS public health colleague presented their joint, in inverted commas, health inequalities plan to the shadow health and wellbeing board which included none of the work that we do in the council and it’s just so astonishing, to be fair they had been told it really didn’t cut the mustard...[they were] I think trying to steamroller on’. (EH manager ID4, site 3)

I observed the HWB meeting (site 3) at which this draft health inequalities plan was presented; there was an ill-tempered exchange which resulted in the Chair (an elected member) sending the report back to be rewritten. This decision was not well-received by their healthcare colleague who had written it (and who has since moved on). A HWB member representing a CCG at the same site (site 3) acknowledged that there were differences in the understanding of health inequalities, but after some discussion about variation in primary care, said that they felt the HWB was managing the issue well.

The vice chair (elected member) of site 1 when asked about tackling health inequalities, suggested a narrow focus on workplace health and the military covenant as a priority, which was in contrast to the wider discussions observed during HWB meetings at the same site, especially from the DPH who was highly committed to addressing the social determinants of health. This interviewee was observed to say very little during HWB meetings and so was not seen to influence the debate;
‘... I think we can do more of that sort of workplace health, it’s me that got defibrillators introduced around Shire Hall and I think it’s more of that sort of thing that we can do... but what effect it will have, I don’t know, but it’s got to have a positive effect I would have thought.’ (HWB member ID16, site 1)

A different experience was reported by a HWB member with a PH role at another site where there was a feeling of a common general understanding and commitment, although this was not nuanced;

‘The health inequalities are huge... but within [area] well recognised. I don’t have to ram any of the health stuff down people’s throats really. They understand the health needs of the population. Without public health being so close to them they’ve already identified that health is a major priority.’ (HWB member ID26, site 4)

Tensions between different parties in the new PH system were explored in greater detail in chapter 5.

When considering enactment relating to differences in understanding, a HWB member involved in writing the JSNA and JHWBS described challenges in gaining the agreement of different parties in the prioritisation of action;

‘Well, the usual thing is we had a development session, you go in with 21 things that could be priorities out of the JSNA and tried desperately to get people to prioritise them, and you come out with 21. They’re not quite the same 21 as you went in with, but you’ve got the same number. So we made an executive decision that we will rank them and take that back to them and say are you happy with this, listen to the discussions. So there is a bit of cat herding. But once we’ve agreed the big broad issues I think for us are clear. The aging population in [area] is a huge issue. If we don’t resolve that one across the partnership then we’re doomed in terms of services. ... The other end of life is clearly important for us, giving every child the best start in life, getting a general shift to prevention... ’ (HWB member ID11, site 2)
An EH manager (ID39, site 11), described their observations on differences in understanding and approach between healthcare and LA colleagues with reference to Marmot. They explained that the medical approach would be to look at the issue or problem, consider the services available to deal with that problem, then set targets based upon the available resources. They went on to say that the LA approach would also be to start with the issue or problem, but would then look at how it might be solved and finally they would put what is needed in place. It was their view that the latter approach was liberating and fitted with the Marmot philosophy, whereas the former did not. It would be interesting to explore this model further in future research at a later stage when policies have been in place for some time.

There were clearly practical decisions to be made by different members of the HWB in balancing their different priorities and understanding, whilst respecting those of others. This is well described by a HWB member;

‘I’m not saying that there’s a common sense of priority because... the need to tackle the social determinants will be at different heights in the in-tray of different... a general practitioner is predisposed to treat the symptoms rather than the underlying causes but the very high quality of GP leadership that we’re enjoying through the CCGs are much better than any GP leadership I’ve seen in [area] historically, so I’m very pleased.’ (HWB Member ID7, site 3)

An EH manager at the same site described their concern that strategies tackling the social determinants must be accompanied by action plans for implementation, but that this approach was not appreciated by health colleagues, who were focussing purely on action plans for health services.

A HWB member at site 4 representing the voluntary sector described a scenario where issues in child development were seen as being of varying priority to different people and they were particularly concerned that issues considered to be too difficult would not be addressed;
there was this statistic around, I think it was 47 or 49 per cent of children don't reach their developmental targets at the 2 and a half year check or the 3 year check....and then we broke off into groups and people were like oh, it's mental health. And you know when you think ‘are you stupid’? [chuckles] ...and the woman from the PCT who was presenting the statistics brushed over it like it was nothing. And it was that for me that was saying it's like ‘oh, well, what can we do?’ ...So it's how do you bring all that together really in a way that it means you change what you're doing to get better outcomes for those children.’ (HWB member ID28, site 4)

A HWB support officer at the same site explained the work that had been done to overcome differences in understanding to ensure that the LA was playing a full role in the new system, describing a shift in their practices;

‘.. this morning, our chief executive asked me to have a look at some hospital performance data around people having too many follow up appointments in hospital and the amount of money that that is spending unnecessarily and, I think, previously, we would have approached that and said, ‘well, it’s an interesting area, but shouldn’t we ask the hospital to give members an update on that’, whereas, now it’s more ‘actually, [name], I want you to scrutinise that, come up with some issues that you think we might be able to get under, so that we’re a bit more informed when we’re asking the question’. (HWB support officer ID30, site 4)

In contrast, an EH manager explained that large projects on health inequalities in recent years, had led to a common understanding in their area that social determinants of health were crucial, whilst recognising the differences in primary care provision, demonstrating the role of local history;

’Soo I think everybody’s got a pretty good handle on what health inequalities are and they don’t like them and I think there’s general understanding that it’s not just about services...people now have decided that half of the life expectancy gap is
because of smoking trends and probably 25% of the life expectancy gap is down to other things that people do and bugger all is down to the quality of the doctor, although we do have good doctors gravitating to posh areas and bad doctors.. end up in the poorer areas ‘ (EH manager ID40, site 11)

There was often a lack of clarity about what strategic priorities would actually mean in practice and how they would be measured;

‘...What that means in practice, we haven't got to that yet...and the health and wellbeing strategy has got to address how that's going to work really; what's generic, what's universal, what's targeted, and how are we going to know if it makes a difference? ’ (HWB support officer and EH manager ID8, site 2) (my emphasis)

In two case study sites, there was a noticeable difference between the discussion of HWB members, as seen during observations, which were generally focussed on healthcare and social care, and the content of the JHWBS and other documents, which were produced by the PH teams and included a focus on the social determinants of health. This was explained by the support officer at one of those sites;

‘..although we’ve got Public Health leading this, there is recognition that the Health and Wellbeing Strategy is not a Public Health Strategy. It’s a strategy for health and wellbeing and really the key determinants around health and wellbeing are jobs, housing – not public health. So I want to make sure that we’ve got slightly more of that in there. Although I have to say that we have had a bit of a disconnect between our Health and Wellbeing Strategy development and what the views of the board are, because I don’t think the Board has been quite strong enough to sort of dictate exactly what it is it wants from the strategy.’ (HWB support officer ID6, site 3) (my emphasis)

This disconnect could perhaps be a result of the pressure to produce significant strategic documents whilst HWBs were very much at the development stage. The approach of the lead person dafting the JHWBS appears to be important, as seen in some dissatisfaction
from other groups external to site 1 to very aspirational targets in the JHWBS relating to the social determinants of health, as a CCG member of a HWB explained;

‘... we had a meeting with our partnership group in [area] where we discussed the strategy... I don’t know if it is to do with politics with a small p or what really, but people were not happy to talk about what they call ‘motherhood and apple pie’, targets around things like eradicating poverty or anything like that, they didn’t want anything seen as so kind of impossible to achieve and you know, and so there’s actually quite a lot of criticism of the strategy... They were really quite, quite rude about it being too full of things that no-one is ever going to achieve and just too aspirational and impractical.’ (HWB member ID17, site 1)

There are clearly a variety of understandings of what health inequalities are and how they should be prioritised, both between HWBs and within the membership of individual HWBs. However, there appears to be an acceptance that opinions will differ and in many cases, an expectation that this will change in time. I have described one example where an espoused individual opinion which differed greatly from that of other HWB members was rejected by those members, and another where an espoused opinion expressed in an interview which was clearly different from other HWB members was not seen to be expressed in public at HWB meetings.

7.4 Role of environmental health
EH is largely ‘invisible’ in the new English PH system (as discussed further in chapter 9) although some EH managers had found a local focus on Marmot useful in promoting their service as having a role in tackling social determinants of health. Others felt that EH managers needed to identify how their role fitted with the espoused priorities of the HWB in tackling health inequalities;

‘They don’t talk about environmental health, they talk about health problems and they base it on the JSNA and that’s exactly the way it should do. So, we’ve just had the Health Profile of 2012, within [area] our issues are low educational
Attainment... diabetes and obesity... the challenge is for environmental health to say ‘how do we link into that?’ (EH manager ID37, site 10)

An EH manager (ID3, site 3) who was a member of an HWB operational sub-group responsible for implementing Marmot principles felt that the role offered many opportunities to demonstrate at a high level how their service could offer a practical PH input. A different EH manager at the same site, explained how they had used Marmot to compile a report demonstrating their impact to the HWB at a practical level, also recognising other LA services and healthcare colleagues as having an existing role in tackling the social determinants of health;

‘...[it] really give examples of what we do within regulation enforcement that fit into each of the Marmot objectives, with a view obviously to trying to get an understanding of what we do in terms of our work to do with public health generally and reducing health inequalities across the board, but obviously we’re only part of that and there is so much that goes on across the council and within the NHS public health, I think that the trick for the health and wellbeing board as it will be is to pull these things together and you can’t do that unless you have a fair amount of knowledge about what goes on...’ (EH manager ID4, site 3)

Another EH manager described how and why the involvement of EH had changed at their authority and also felt the need to recognise the role of other LA services and to set out how joint working would happen in practice;

‘...when I arrived, I was quite shocked to find that environmental health was not part of this whole drive to tackle health inequalities, partly because...I think, we had a head of services then who was not really engaged in the agenda... [and]as a profession as well that has, over the last few decades, found itself increasingly going down the regulatory route... so the County have said, look, we recognise that you are delivering a lot of public health at a local level through your environmental health teams, your housing teams, through your leisure services, your regulatory
side, your licensing, housing advisor, homelessness, you know, we do an awful lot of public health here, not necessarily called environmental health, so they’re saying, we recognise that and we need to agree with you how we’re going to work together.’ (EH manager ID41, site 12)

An EH manager hoped for more recognition of the achievements and future potential of EH, including in the relationships with local businesses;

‘..what I would like to see for environmental health is a better recognition of what we do to some of the priority areas, an example.. we were instrumental in developing supplementary planning guidance that reduced the proliferation of hot food takeaways in certain parts of the borough and close to schools, it was something we got up, we provided the evidence base, we provided a monitoring mechanism for the planning service...yet, we never get any recognition for all that ground work which we did..., we’ve got a better commercial interface with local businesses than anybody and we’re in them regularly, we know where they are, we know who the key contacts are, they trust us and ...we’re in a position of influence like, perhaps, nobody else within neither the PCT or the Local Authority.’ (EH manager ID3, site 3)

An EH manager (ID43, site 14) who had successfully made a case for funding from the PCT to tackle health inequalities via a housing improvement programme felt that Marmot objectives had helped them to demonstrate EH impact during project negotiations and discussion of outcome measures. However an EH practitioner in a two-tier system in site 10 explained that in practice their role in the new system was quite confused;

‘..they’ve come to us and they’ve said ‘here’s a website platform – populate it’, so ...we’ve been putting in a bit of stuff about air quality, we’ve put in a bit about contaminated land. But it’s been quite difficult to know exactly what they are after’. (EH practitioner ID38, site 10)
There are similarities and differences in the enactment in policies and practice of EH in relation to health inequalities. Some managers felt that Marmot had provided a useful framework to demonstrate impact, whereas at one context site in particular the situation was muddled.

7.5 Measuring success
Following the end of the data collection period, various management tools have been published to assist in HWB self-assessment, see for example (NHS Confederation 2013), however these were not available at the time of the research and so are not reflected in the findings or discussed further.

There were differences of opinion about what HWB success would be and how it would be measured, but several interviewees felt that health inequalities would be an important indicator. However, in practice this was proving to be a difficult task as illustrated by the following quote;

‘[HWB chair] is very keen to have some sort of metrics that show what the added value at the health and wellbeing board has been. Which is of course incredibly difficult. You’ve got something the whole system is doing, how do we know it’s because of the health and wellbeing board? And he’s absolutely right that there’s no point sitting around talking, having a talking shop. It’s got to make a difference. It’s nice to see the performance people wracking their brains. Because you can look at what’s happening to life expectancy, what’s happening to inequalities, what are our immunisation rates doing, but actually which of those bits, if any, are due to the health and wellbeing board?’ (HWB member ID11, site 2)

A support officer at a different site expressed concerns at the possible metrics used to measure success, and how they could potentially be misleading or lead to unintended consequences;

‘..they’re two parts of the same thing; health inequalities and health improvement. Everybody’s health is improving, but some people’s health is improving quicker
than others. So, when we judge our work in several years time, do we say well we haven’t closed the gap in health inequalities…but people are living for two years longer now and in better health. So, I think there’s one argument to say that actually to reduce health inequalities you have to improve health slower …it’s not straightforward at all. And I think we would be unwise to judge whether this, this whole setup succeeds or fails on one health inequality metric.’ (HWB support officer ID14, site 1)

An elected member of a HWB was keen to use a broad range of indicators to measure success and to consider benefits to wider society, as well as to the individual;

‘I think quite a lot of it is about outcomes for children, leaving schools, NEETS, work opportunities, length of stay in jobs, length of stay out of work, you know, all of those sorts of things are, to me, really important decisions, because that’s a litmus test of success of communities of society, whether you’re actually getting it right.’ (HWB member ID18, site 1)

A LA officer member of a HWB explained how they felt success should, and should not, be measured arguing against performance management at that level;

‘We’ve had quite a long debate about…and this could be one of the successes, of course, about what is it that the board is actually going to measure and I’ve been fighting a bit of a rearguard action to make sure the board doesn’t consider itself the right place for performance information and arguing against having a performance subcommittee... What I do think the Board should do is sharpen up the strategy outcomes so that they have something that can be measured and, in the end, that may be a basket of indicators that would be contributing, but it would be about recording achievement of outcomes.’ (HWB member ID20, site 1)

It is clear that measuring success, particularly with regard to health inequalities is not straightforward, and there is some debate around the level of measurement, particularly performance management, that the HWB as a strategic body should be involved in. Interestingly, none of the interviewees discussed the PH outcomes framework during discussions around measuring success, although it was published in 2012.
7.6 Conclusion
I have described a situation where there are both similarities and differences in espousing and enacting in relation to health inequalities. Differences were particularly apparent at two case study sites where the JHWBS was written by the PH team and some HWB members expressed feeling a loss of ownership. This may have been a consequence of the pressure to produce strategic documents at such an early stage in HWB development. Several interviewees expressed the feeling that strategies were drafted at an earlier stage than the HWB was ready for, or had been based on existing documents and were to be refreshed at a later stage, and this is supported by observational data where there was seen to be great pressure to produce JHWBS in time to feed into the CCG authorisation process.

There are also differences in opinions on measuring success, and at the time of the research these questions were largely unresolved at the case study sites. Further research on this area when HWBs have been established for more time would be very helpful in assessing whether enactment in strategy is followed by enactment in practice.

It was interesting to note that the most overt commitment to Marmot was seen at the case study sites, when compared to the contextual sites where at least two interviewees felt that health inequalities was not on the agenda locally and another felt that they had been given a low priority. This demonstrates the benefit of including contextual sites recruited via my professional network, as it is highly unlikely that such sites would have agreed to take part in research focussing on health inequalities.

Chapter summary
There are both similarities and differences in espousing and enacting in relation to health inequalities with a variety of approaches taken. However a commitment to Marmot priorities was seen across the majority of sites. In many cases, it appears that this is due to the absence of alternative frameworks and guidance available at the time of HWB development. It remains unclear how HWB success will be measured.

This chapter addresses the main research questions 2 and 3 relating to health inequalities and the role of environmental health.
8 Evidence based practice

This chapter discusses how EBP is increasingly seen as essential for medical and PH occupations; considers the implications of this; explores the responses of EH practitioners and managers to this development; and looks at how they propose to adapt to future expectations.

Evidence based practice (EBP), as I have discussed in chapter 1, has become a medical norm in rhetoric, if not always in practice. Whilst this has been established in medicine for some time, it has not been true for LG occupations, where local strategic decision-making has been the prerogative of elected members, advised by officers who do not have a tradition of EBP. This is not to say that the idea of EBP in EH and other LG professions has been dismissed historically - however it never became established as an expectation of good practice, as one interviewee recalled;

‘.. I can remember when I was at college in the mid-eighties, our head of course at Leeds, was then saying, Environmental Health has to be better at evaluating the projects it does, and saying how good it is. And we’re still not good at that.’ (EH manager ID44, site 15)

Interviews with EH practitioners and managers have revealed both individuals and the wider body struggling with accepting the need for, and the practicalities of, adapting to an EBP approach in order to survive and establish some credibility in the new system. There is also some evidence to suggest that other LG occupational groups, such as social workers find themselves in a similar situation (Fronek 2013).

The wider issue of the future of EH in the new PH system, including EH as ‘doers’ is discussed in chapter 10.

8.1 Evidence based practice as the norm

This research indicates that there is an expectation that EBP will be the norm for PH practitioners in the new system. Very many EH interviewees reported experiences of EBP starting to dominate local expectations of PH practice, with EH struggling to demonstrate its value in these terms;
'Because, of course, that’s the way that the NHS works. You can’t get funding for any project or anything without having an evidence base behind it, which, of course, environmental health doesn’t traditionally have ... and for example – why do we do food inspections? Where is the evidence base that they succeed or are worth funding?’ (EH practitioner ID45, site16)

As I will describe in chapter 10, EH practitioners and managers have observed that statutory functions are being lost, and new skills in securing funding are required to thrive in the new system, including being able to provide evidence of outcomes. As also discussed in the same chapter, this research has found that EH practitioners see themselves as ‘doers’ compared to other PH colleagues as ‘thinkers’ and the role of evidence is key in this perception;

‘... the thing that I have in the back of my mind is people in the NHS seem to be very fixated with evidence based practice and, of course, environmental health, we just do it.’ (EH manager ID1, site 3)(my emphasis)

The availability of evidence of outcomes, rather than outputs in terms of inspections or other interventions is felt to be necessary to secure funding, if services (and ultimately jobs) are to be protected;

‘We’ve barely scratched the surface of the analytics of some of the tobacco work,[but] we’ve actually got reasonable numbers about what we’re doing. But big questions about does enforcement influence price? Does it influence availability? What will an elected member get for their money? If they give us another enforcement officer will there be measurable health impact? Are we just a finger in the dam wall and the best we can say is it’s not getting any worse or are we actually making a difference? If we can actually show a meaningful cause and effect in terms of outcomes for say tobacco work I think the balance of spending from that would be different.’ (EH manager ID46, site 17)(my emphasis)

8.2 Evidence based practice lacking in environmental health
EH does not have a tradition of EBP, and this is the case both in using the available evidence for decision-making (including accessing it), and also evaluating and writing up
their work to contribute to the development of an evidence base. Very many EH interviewees reported feeling unable to provide the evidence required of them in the new PH system;

‘...there’s lots of information out there to say what the problems are, but to prove that what you did had an impact, is very difficult, and because it’s evidence based, everyone’s looking for you to prove it. So, that is tricky.’ (EH manager ID36, site 9)

Other interviewees agreed that they had encountered difficulties in measuring the outcomes of EH work, which is primarily preventative. One EH manager reported challenges in negotiating for time to measure longer-term outcomes in a system where short-term outcomes are of greater interest, giving an example of issues arising during a smoking cessation project;

‘...it was a battle to get the money and it was a battle to stop it getting shat on (pardon me) by the Performance Manager at the PCT. It was a battle to get people to keep their faith when nothing’s happened. You know, you’ve been doing it for six months and nothing’s happened.’ (EH manager ID40, site 11)

Many EH managers shared these difficulties in measuring the PH outcomes for their services, feeling that relying on less tangible outputs as a measurement of effectiveness was rendering them vulnerable to a loss of resources;

‘..if your service is doing well and you don’t have the numbers of prosecutions and notices served, or homelessness cases, you know, there’s a temptation for the members to think that there’s too much capacity in those areas, they’re thinking, well, there isn’t a problem, therefore, we don’t need so many staff, but it’s actually the front line work that’s going on that’s preventing that kind of thing.’ (EH manager ID35, site 8)

Others felt that the EH experience was also true for other LG occupations;

‘.. we do a project and it often is pretty good, but we don’t necessarily review it, we don’t document it... we have some outcomes, but most often they are usually figures,
aren’t they? They’re not.. what have we actually achieved from a public health point of view and we don’t share it very often... But then I don’t necessarily think we’re on our own within local government being like that..’ (EH manager ID1, site 3)(my emphasis)

There was general agreement that EH practitioners were carrying out a lot of good, effective work, but were failing to evaluate, write up and publish, in order to develop the evidence base now required;

‘... the reality is there’s people out there experimenting every day of their life, but they don’t realise they’re doing it, and they’re not recording it, well they’re not doing it in an appropriate way perhaps, but they’re not recording it either, and they’re not sharing, except in anecdotes.’ (EH practitioner with national role ID33)

There also appears to be an expectation from PH colleagues that evidence will be quantitative or ‘medical’;

‘...what I see in terms of what evidence will be used to make decisions and, without a doubt, most of it is medical; there is still a lack of environmental/social evidence, I think that is of higher status, if you like and, and powerful enough to affect decisions...it is much easier to churn out some of the medical data more quickly and some professions have much more of a culture of that than others. So I think that is going to be quite a stumbling block, particularly if people have to fight their way in, rather than, are welcomed in on an equal footing.’ (EH practitioner and academic ID42)

It can be seen that there is not simply an issue with a lack of evidence, but that the type of evidence and the way it is presented is seen as crucial in being accepted as a PH profession of legitimacy and value. There were very real concerns reported about the impact of a lack of EBP in EH and the consequent inability to present the available data effectively inhibiting engagement as equals in the new PH system;

‘...unfortunately, well fortunately or unfortunately, fortunately the public health in the NHS, they do that very well... So I think there’s a danger we’ve got there of not
being able to be part of it... I think the only way we are going to prove ourselves, is, is by the results we give and that’s how I go back to measuring stuff.. because it’s very hard to go to these meetings when they’ve got massive graphs and it’s all very well presented and we turn up with ‘well we did all this’ and it looks like a bit of scrap of paper with, so it’s how we present ourselves, how we get ourselves on a level playing field really.’ (EH manager ID1, site 3)

One interviewee took this concern a step further, by identifying the risk that EH would lose out to more organised ‘others’;

‘...the people who are good at that may get ahead of us in the queue and we’ll still be going: You can’t cut this. You can’t cut this. This is so important..’ (EH manager ID46, site 17)

There were specific concerns that funding could be lost;

‘...there hasn’t been the research done to be able to just go and find a paper that says: Environmental Health – this project should be funded – because it makes this much impact. That research doesn’t exist – or it hasn’t been published’. (EH practitioner ID45, site 16)

Others were concerned that the lack of evidence could affect the ability of EH to engage effectively with HWBs;

‘...if we really want to have an impact on those Boards and in strategy and also make sure they’ve got the right resource it’s to have – you have to have the right research and the background to prove your case.’ (EH manager ID34, site 7)

It is clear that interviewees felt that the lack of evidence is having an impact not only on the perception of EH as a PH occupation, but also on the ability to play a full role strategically and to secure funding for services.
8.3 Impact of EBP on relationships with public health colleagues

Several interviewees reported that the combination of expectation for EBP and lack of evidence in EH had caused tensions with PH colleagues, with one interviewee noting that the evidence base is ‘like a religion in medicine’ (EH manager ID40, site 11). Others described the medical expectation to follow EBP as a potential cause of delays in decision making for issues which require fast responses, and had found this to be frustrating, again reinforcing the EH practitioner idea of themselves as ‘doers’ compared to other PH occupations;

‘...sometimes [there] has been a very good reason for the medical side to be very slow moving, very cautious... whereas we sometimes have to be quite rapid and say I really want a bit of work done around this- will you draw me up a quick bit of policy and strategy for this and let’s see if we can get something in place within the next three months?’ (EH manager ID46, site 17)

One interviewee described a particularly uncomfortable situation in a meeting with PH colleagues, when they questioned the use of the medical EBP norm to secure EH funding;

‘But I also asked him, at this same meeting (laughing) – are you going to expect everybody that wants funding to provide you with an evidence based case, for why they require the funding and he looked at me like I was insane for even supposing that that wouldn’t be needed.’ (EH practitioner ID45, site 16)

Others alluded to a skills gap in terms of developing and using an evidence base in EH, but this was mentioned infrequently and indirectly. There was some hope expressed by several people that the relocation of PH colleagues to LAs would provide a combined skill set that would help plug the evidence gap in EH;

‘..if we can make use of analysts, statisticians that are coming in from maybe from the PCT we then, possibly, [will] be in a better position to start contributing better and making a stronger argument when it comes to looking at priorities.’ (EH manager ID31, site 4)
However, an EH manager expressed concerns that the move back to LAs would lead to a loss of access to the evidence by formerly NHS-based colleagues:

‘..where there is evidence they’ve got their finger on the pulse and I think we’ve not been particularly good at within the local authority is we’re good at describing numbers in terms of what we do... that’s still a challenge for us and I’m hoping that we can learn from the NHS, but interestingly.. they’re worried by coming over, moving the public health stuff over to local authority they will lose those links and so that whereas now within the NHS they can you know they can go to somebody and say ‘ooh well can you tell me what the obesity rates are in all the wards in [area]’, if they’re not working for them, those links may diminish and I so I think that would be a challenge, but in terms of where they get information from and how they present it, they are streets ahead of us, I mean we can learn from that.’

(EH manager ID4, site 3)

This research has found that the need for evidence has added a layer of complexity, and also sometimes tension, between PH occupational groups as they are required to co-operate and may be competing for limited funding. Nevertheless, there is optimism that many issues can be overcome by working more closely together, learning from others, and playing to their relative strengths.

8.4 Historic focus on outputs
Many EH practitioners and managers expressed the view that the historic focus on outputs was proving unhelpful and regretted measurement of the job role and impact by other bodies in this way, (such as the FSA for food hygiene inspections) had not been challenged earlier;

‘..we’ve, sort of, allowed ourselves, as a profession.. to be measured by the number of inspections we did, how quickly we turned around, how many high risk, medium, low risk and the same with health and safety. So we should have been more robust
in challenging that, you know, we were, when we started out at, as a profession, we were very challenging.’ (EH manager ID41, site 12)

An EH manager expanded this theme, adding that outputs measured were often targeted at the wrong issues;

‘We wanted to be a risk based /intelligence based service. That means we are trying to move from being output based – how many inspections do you do? So what? What difference does it make? Even if you’re fully compliant with the Food Standards Agency requirements, so what? We’re trying to get to the point where we’ve got enough intelligence and needs assessment generally to be able to start challenging. Why are we doing all of those inspections when we should look at the size of the issues – is it food poisoning or is it obesity?’ (EH manager ID34, site 7)

Research findings relating to the focus on outputs and enforcement as limiting are discussed in chapter 10.

One interviewee felt that the Chartered Institute of Environmental Health (CIEH), the national body for EH, had been remiss in not establishing EBP historically;

‘I think it comes back to the thing about evidence and we haven’t got the evidence as a profession and that’s our own fault really, but I think the CIEH hasn’t been as rigorous as might have been in that respect.’ (EH practitioner and academic ID42)

It is evident that the historic focus on outputs is seen as limiting and there appears to be a feeling of regret that they as individuals, and as a national body, have not challenged this effectively in the past.

8.5 Evidence based practice as hindering

Despite the above, several interviewees reported negative experiences of EBP, and felt that in practice the concept was limiting, in terms of innovation in dealing with novel problems, obtaining funds for pioneering work, and ensuring a speedy response;

‘one thing I would say about NHS public health officers is that they’re very good at justifying what they do and I’ve had a few shall we say interesting discussions
because they, they’re always going on about everything’s got to be evidence based and I do understand that that’s important but there are times when you haven’t got the evidence, you can’t get the evidence, for instance the work that we’ve done with sheesha, this has been unique, if we’d scratched around trying to find some evidence that it’s a good idea to go into a sheesha premises and stop them operating illegally, well, we’d still be examining our navels quite frankly, sometimes you just have to go there and get on with it and interestingly some of the NHS colleagues have agreed with that view,’ (EH manager ID4, site 3)

One interviewee expressed concerns that EBP was being used in a very limited way, resulting in a backwards-focus;

‘We only know about what we have been doing, we don’t even research that well enough but we certainly don’t research what we could be doing- and so everybody who is looking at the evidence base is looking for the things they are already doing, well that’s a distortion we can’t live with.’ (EH practitioner with national role ID33)

This suggests that the view that EBP was a good thing in itself was clearly not universally held.

**8.6 Reasons for not evaluating and publishing**

When asked about why EH did not have a tradition of EBP, a variety of ideas were suggested, although by far the most common response was lack of time, often related to how they were currently measured in their role;

‘..if your job is to do that and to crunch out the statistics, because that’s what it comes down to, how do you then find the time and the energy to do the things that actually might be more important and have more of an impact on health?’ (EH practitioner and academic ID42)

An EH practitioner, who appreciated the need to create and use an evidence base, when comparing EH with other PH colleagues, felt that the time issue must be overcome;
'One of the things that really shook me was I, I spent a couple of days working for the HPA, and I noticed how good they are at evidencing what they do... when you read their monthly report book... it’s just so professionally done... and you think well, should we be getting more serious about that in Environmental Health? I think we probably should be... that we do seem to be too often just sort of chasing our tails round, setting fixed penalties for littering when we should be looking at (I’m not belittling what we do on a day to day basis) but there should be some time put aside to do these types of projects’ (EH practitioner ID38, site 10)

An EH manager considered EBP a ‘luxury’ rather than a necessity, where resources are tight, but had hopes for future working with PH colleagues following their relocation;

‘We’re a streamlined service, we don’t have much fat on the makeup of the teams and finding time to look into research, look into developing and building base line data that you can work from is something that we don’t have the luxury of being able to do, that’s one of the things I’m hoping, public health coming in to local authorities might help us with’ (EH manager ID31, site 4)

Interestingly, there was very little direct mention of a lack of skill or confidence in being able to evaluate, write up and publish projects; this was surprising given the high level of interest and their perceived need to develop research skills seen in attendees at workshops on these topics organised by the UK Environmental Health Research Network (EHRNet), founded by five academics (including myself) with the aims of promoting research and publication in EH.

8.7 Success stories
There were two notable success stories in the use of EBP reported by EH manager interviewees, both working in cities, though at different ends of the country and in very different circumstances. The first relates to success in levering in funding for housing interventions to tackle health inequalities, by quantifying spend on EH and modelling for savings in health and other public spending;

‘We’ve had very long debates about outcomes and outputs because you know these things are so difficult to measure, you know if you’re exposed to substandard
housing the symptoms may not manifest themselves for 5, 10, 15 years and there’s no way you can have a sort of impact assessment or evaluation done in a short period of time, but what we are able to do is model... So EHOs in year 1 cost roughly £300,000 in salaries levered in by in terms of landlord improvements several hundred thousand pounds and will be saving, or are estimated to save the NHS £4.4 million over 10 years and wider society £11 million.’ (EH manager ID43, site 14)

The second EH manager had used a variety of approaches to demonstrate the effectiveness of their service;

‘..we’ve done quite a bit of evidence based evaluation but it’s been both qualitative and quantitative, so we have done quite a lot of feedback on a qualitative manner, so interviews as well as the nub of how many referrals, to whom and all that sort of stuff...and it is quite difficult when you get asked; right, what are your outcomes, what are you monitoring to actually come up with something that’s useable? Because we tend to deal with things over a longer term so it is quite difficult sometimes, but I think we’re creative.’ (EH manager ID48, site 19)

These limited examples demonstrate that EBP is possible in EH, that it is happening in some areas, and perhaps also more importantly, that it has been used effectively to protect and grow services following the recognition of the PH impact of EH work.

8.8 The future
Building on the success stories, there was some positivity expressed by interviewees around the practical steps that could be taken to start evaluating; giving sufficient thought to how success will be measured at the planning stage of a project;

‘So you’re looking at it at the beginning going; right, okay, well, what do we want to achieve and how are we going to monitor it? Not doing it and then getting halfway through going; what have we done and what have we achieved, you really need to start at the beginning and do it then... ’ (EH manager ID48, site 19)
Others felt that being able to demonstrate the value of EH work would make an impact in how they are perceived;

‘If we do this and we show the benefits, then it’s going to be a lot of benefit to us, because people will say, ‘Well look, Environmental Health, they’ve really delivered here.’ (EH manager ID36, site 9)

An interviewee with a strategic role in LG expressed an openness to considering the value of non-medical evidence for PH;

‘.. probably it’s easier in housing where there was a bigger national evidence base.. if ..the housing intervention costs a few hundred pounds, but could potentially save thousands of pounds in hospital treatment, that’s where you actually do start getting people going, oh yeah, and then you can tie that back to the JSNA... I think it’s about normalising what you think of as public health.’ (HWB support officer ID30, site 4)

There are signs that EH practitioners and managers feel that by evaluating their work in terms of outcomes, they will be better able to demonstrate the benefits of their work, and there are signs that some PH decision-makers will be open to this evidence.

8.9 Conclusion
This research suggests that the medical norm of EBP is fast becoming the expectation in the new PH system. This reality has caused problems for LG PH occupations, such as EH, who are not geared up to evidence their work in terms of outcomes, having historically been measured by external bodies, (such as the FSA) in terms of outputs, such as the number of routine inspections carried out on time. This puts EH at a disadvantage when demonstrating its value as a PH occupation, and it is felt, may impact on service funding in the future.

EHPs and managers recognise the deficit, and whilst they may not all agree on the value of EBP in itself, they do see that being able to demonstrate effectiveness in this way is necessary to survive and thrive in the new system. There is some optimism that the evidence base can be developed, particularly if efforts are made to work with other PH colleagues more familiar with the concept, however there does not seem to be any
willingness to compromise on the requirement for EBP by other (primarily medical) PH professional groups. It was not possible to interview very many people with medical backgrounds for this project and a deeper exploration of their views on EBP and the preparedness of their LG PH colleagues in this respect would be an interesting area for further research.

It is evident that the changes to the PH system have resulted in the medical norm of EBP becoming the expectation for other PH occupations, including those based in LG, who have not been previously required to demonstrate their effectiveness in this way.

**Chapter summary**

EBP has become expected practice in the new public health system. The concept is familiar to those with health service backgrounds, however there is not a tradition of EBP in professions with local authority backgrounds, such as EH. There are concerns that the ability of local authority public health professions to secure funding may be diminished as a result.

This chapter does not directly address any of the research questions as the theme emerged during analysis of the data. However, it does contribute towards answering question 3, in that it provides an insight into how EH is seen (or not seen) as having a role in tackling health inequalities.
9 Environmental health; The ‘doubly invisible’ public health occupation

This chapter will discuss why environmental health EH is ‘doubly invisible’, being unseen and often misunderstood within its own culturally invisible context; whether in LAs, among HWB members or by other allied groups. Suggested reasons for this double invisibility are also discussed, along with consideration of what the future might hold for EH in attempting to overcome this disadvantage.

Public Health (PH) has been described as being ‘culturally invisible’ to the outside world, in that its achievements are eventually taken for granted and forgotten and its impact is primarily based on what might happen; ‘the drama of threat’ and the occasional attention-grabbing crisis (Rayner and Lang 2012:4-5), for example a food poisoning outbreak or workplace fatality. This research suggests that EH is also invisible within the culturally invisible PH arena to which it belongs, as a HWB member describes;

‘They’re so good at what they do, you don’t hear about them. You’d only hear about them if there were diseases all over the place and infections breaking out and premises being closed and all that.’ (HWB member ID10, site 2)

Wider issues relating to EH in the new PH system are considered in chapter 10. The historical position of EH in relation to other PH occupations is discussed in chapter 1 and structural matters concerning the position of EH in relation to HWBs and their sub-structures were set out in chapter 4.

9.1 Environmental health is invisible within local authorities

As I have discussed in chapter 1, EH is a LA-based occupation and LAs may be structurally unitary or two-tier, depending on the geographical area. The research results indicate that EH is doubly invisible in both unitary and two-tier LA areas, which is somewhat surprising, given that EH is part of the same organisation as the HWB in unitary areas.

Some EH practitioners and managers in unitary authorities described the frustrations they felt in gaining recognition for the contribution of their services in LA PH plans and strategies;
‘I downloaded all the Health Inequality Plans I could find... and they all do start with ‘we have a huge problem with Mental Health, therefore we must sort out the services that people with mental health issues will have to contact’. But they don’t actually look at what’s caused the mental health issue and the problem in the first place. Is it because they are exposed to environmental factors that are destroying their mental health? And that’s where Environmental Health comes in, and that’s the bit that’s not seen and not appreciated and included in these Health Inequality Plans. I haven’t found one that includes anything to deal with the fact that Environmental Health deal with noise complaints and noise complaints have a massive impact on mental health...’ (EH practitioner ID45, site 16) (my emphasis)

EH practitioners and managers in two-tier systems commonly felt that their role was unseen or ignored by HWB members and allied occupational groups based in the upper-tier, although this could perhaps be a function of the structural arrangement, rather than the overlooking of a particular profession;

‘Well, some of the Public Health documents that have come out - I mean the way they view the Local Authority function – they’re talking in terms of Planning, in terms of Culture, in terms of Leisure – Environmental Health doesn’t actually get a mention’ (EH practitioner ID38, site 10)(my emphasis)

‘I would have thought at county level.. they hardly know I exist…’ (EH manager ID36, site 9)(my emphasis)

Other interviewees focussed on the practical difficulties they had encountered in trying to gain recognition, both at the personal level and in relationships with medical colleagues, where there is often little common language or understanding;

‘It’s hard, at some of those meetings, you do feel a little bit overwhelmed by the background knowledge of some people coming; health and wellbeing strategy work that’s been going on, the JSNA work was very clinically orientated ... when I first sat on that group, and I thought to myself, this is an area we’re so alien to... with so many other people around the table, it’s going to be quite difficult getting my voice heard.’ (EH manager ID31, site 4)
Tensions in relationships between different parties in the new PH system were discussed in detail in chapter 5.

An EH manager in a district council described challenges in raising the profile of EH with elected members, as ‘reports for information’ were no longer being submitted and a restructure had removed the committee with specific responsibility for the service, but went on to suggest other possible avenues of interest;

‘The trend in the last few years, as you’ll know, is that all the committees that we used to take information to, we used to have an environment health committee, ...[but] it’s disappeared, so we don’t have the information papers going to executive...and so councillors generally don’t hear about environmental health. So, I’m hopeful that the health overview and scrutiny committee will be an area where we can get information in.’ (EH manager ID 23, site 1) (my emphasis)

In summary, the research findings indicate that EH is overlooked or unrecognised in LAs in unitary and two-tier systems, and also by both officers and elected members and it appears that the main issues are of communication between functions and individuals.

9.2 Environmental health is invisible to Health and Wellbeing Board and public health colleagues

During research interviews, HWB members and support officers were asked what they knew about EH, and the majority of responses either revealed a very limited knowledge of the role or showed an awareness of few functions, primarily listing food hygiene as the main EH activity. The following comment is indicative of many responses;

‘I: Can you tell me what you know about EH?

R: Not a lot really, I mean, it’s not really come to the board’ (HWB member ID5, Site 3)

There were few interviewees who showed an understanding of even a small range of EH functions, although several expressed surprise at the extent of the role when they did find out about it (often as part of the research interview process) and this was the case within both two-tier and unitary arrangements;
'I haven’t had lots of opportunity to work with Environmental Health, but recently, I suppose, in the health agenda, that’s when I have had the opportunity to find out a little bit more about their role and I’ve actually been quite surprised at their remit.’

(HWB support officer ID30, site 4)

In addition to having a very limited idea of the remit of EH, some interviewees greatly misunderstood the role, for example mentioning streetlighting and cutting bushes (however, this could have been a function of local organisational structures where people were working in silos in unitary authorities). A HWB member suggested the invisibility could be the result of a lack of understanding and appreciation of the EH role;

‘I mean is it about people’s understanding of what EHOs do?’ (HWB member ID11, site 2)

The feeling that HWB members had very little understanding about EH, was supported by EH practitioners and managers, who felt it was misguided to assume that the EH role was obvious to others in the PH system;

‘I think one of the mistakes that people make is that we sit back and go ‘oh environmental health, everyone knows about us’ and none of them do. They have no idea. No idea.’ (EH manager ID37, site 10)(my emphasis)

There were mixed responses regarding the understanding of EH by others working in PH, with Directors of Public Health generally better informed than their teams and colleagues on HWBs. An EH Manager in a borough council described a positive response when PH colleagues were introduced to EH and understood the role;

‘[The PH team] they’ve work shadowed, so they’ve been around, they spent a week going out with the environmental health team, so they were, you know, they were blown away actually... they didn’t realise just how much public health work we did’

(EH manager ID41, site 12)

Others described a real sense of frustration in getting the message that EH is a PH profession across to allied colleagues working in the area;
‘I think, people have just been exasperated, I’ve had a few people saying, oh, but we are Public Health, it’s just we’re Local Authority Public Health and it’s, like, yes, I know, we need to keep repeating it to our new director of public health.’

(HWB support officer ID30, site 4)

The research findings suggest that EH is largely invisible within the PH arena, but that in many (not all) cases where there is successful communication of what the role involves, the response / interaction is generally viewed as positive.

During interviews where the issue of invisibility arose, people were asked why they thought this was the case. There were a variety of suggestions including the name, fragmentation and lack of clarity in the role, organisational structures and the domination of health and social care forcing other issues off the HWB agendas. These are discussed in further detail below.

9.3 What’s in a name?

As I discussed in chapter 1, the name of the occupation currently called environmental health has changed several times during its long history. With the benefit of hindsight, there was much regret expressed by interviewees at the most recent name change from ‘public health’ (the term being first used in 1956) to ‘environmental health’ in 1947 (Cornell 1996, Chartered Institute of Environmental Health 2003), and it was widely felt that the loss of this simple flag of the primary role has affected how the occupation is perceived by others in the arena;

‘People don’t think of environmental health as a public health thing, strangely enough, and that’s probably because the profession chose to call it environmental health rather than public health, which I think in retrospect is a mistake. I think it is public health and that would have focused people’s minds on what it is about, so I think it is our own doing largely’ (EH manager ID32, site 5)

One interviewee was satisfied that they had retained the PH title for their service and felt that this was helpful;
‘..we wanted to make it very clear at the start that the title of the services is not Regulatory Services or Environmental Health – it’s Public Health and Protection – so the fact you’ve got Public Health within the title of the Service.. I often am aligned and speak with the drift of Public Health,’ (EH manager ID34, site 7)

Very many EH practitioners and managers expressed the view that EH was part of PH and felt no doubt that they have a vital role in the new system, even if this was invisible to others in that system;

‘So the minimum amount of problems with your house, the minimum amount of noise and chemicals that you should be exposed to at work, and the likelihood that you’re going to be killed or lose your foot or these kind of things, and I think we are quite vital. It’s quite a vital role, but it is quite unseen I think.’ (EH practitioner ID45, site 16)(my emphasis)

‘..to my mind, fundamental to Environmental Health, because we are not Environmental Health, but Public Health, in my opinion. You know, if we’re not involved in that, if we’re not part of the process, then there’s something seriously wrong with it.’ (EH manager ID36, site 9)

It does appear that the change in title from PH to EH, in retrospect, was perhaps unhelpful as practitioners now find themselves in a system where establishing PH credentials seems to be key to gaining recognition and playing a full role. However, the retention of the name would have necessitated a different title for the arm of PH that returned to the NHS; perhaps a ‘healthcare PH’ and ‘local government PH’ distinction would have been possible, reflecting the complementary and interconnected roles.

9.4 Fragmentation and lack of clarity in the role
Many EH interviewees expressed the fragmentation of functions as an issue in the loss of identity and recognition by others;

‘I think, we fragmented, we’ve lost some of that identity and, I think, therefore...we’re less easy to understand by people observing us and looking at us,
an environmental health officer to one person, could be, ‘oh, he’s a noise officer, isn’t he?’ (EH manager ID41, site 12)

Others suggested a lack of clarity around the EH role as a factor;

‘... environmental health practitioners have prided themselves on the fact that, you know, we’re a jack of all trades and a master of none and we’re always the meat in the sandwich, we are the people who put you in touch with other people, but I also think that doesn’t sometimes be recognised as adding value.’ (EH practitioner ID24, site 4)

Several interviewees suggested that the current difficulties have been largely self-inflicted, for example, tolerating poor practice;

‘I’ve seen some dreadful environmental health officers, in my time, I’ve seen some good ones, but I’ve seen some dreadful ones and we don’t do ourselves a lot of favours sometimes.’ (EH manager ID41, site 12)

The same EH manager felt that the occupation had ‘lost its way’ and again this is discussed in greater depth in chapter 10;

‘public health is lost in the NHS and, as a profession, [we] never really got it back, not really fought for it back either- because we were too busy doing, you know, closing food premises down, and things like that, and dealing with more technical issues, so, I think, we lost our way as a profession’ (EH manager ID41, site 12)

I have only briefly touched upon fragmentation and identity here as the issue is discussed in greater detail in chapter 10, although it does appear to be a relevant factor in the invisibility of EH.

9.5 Organisational structures and cuts
There were issues around the impact of structural arrangements; some interviewees felt that fragmented or ‘siloed’ local regulatory organisational arrangements were potentially confusing in establishing a clear identity and visibility. Very many EH interviewees mentioned that housing and other functions were part of a different department;
‘...different Councils do it differently, so you can have an Antisocial Behaviour Unit that’s nothing to do with Environmental Health, that stuff like that would get shunted across to, once it gets to that stage and then [at] another Council, it would be the EHO all the way.’ (EH practitioner ID45, site 16)

Some also felt that EH was being lost amongst other functions in large directorates and noted a disconnect between the regulatory occupations, such as EH, trading standards and licencing. Others felt that not being located in the same department as the statutory HWB members was a disadvantage, which had resulted in the service being overlooked;

‘I was under the same department as head of policy, or if I was in the same department, or was in the Public Health Department, or I was with adult social care, if we were closely involved with the health and wellbeing board, I think, that work would be recognised... ’ (EH manager ID31, site 4)

It was also felt by many respondents that EH was generally suffering as a result of LA spending cuts, and that this was having an impact on the service, contributing to the loss of clarity and focus, which was also expressed by others;

‘..it seems to me that the districts and boroughs are downgrading their environmental health services, which is a concern and I think that’s happening right across the country, partly with the cuts and partly because of a lack of focus on what environmental health does.’ (HWB member ID15, site 1)

Additional findings relating to the effects of LA cuts on EH are described in chapter 10.

9.6 National leadership
The CIEH is the national body for EH, however there is no membership requirement for practitioners and many choose not to join. The CIEH had developed some publications nationally and campaigned at a high level for recognition, however the impact did not appear to be felt locally. There also were some concerns regarding weak EH representation at a national level being a factor in visibility, when compared to other occupational groups;

‘I think, there doesn’t seem to be that national voice either, because when I was doing the JSNA, the housing, the National Housing Agencies and the forums that
housing was supposed to link into had a really strong voice about housing is really crucial... had a huge evidence base around housing interventions, we’ve got RSL, lobbying and saying it’s wrong that we’re not on the board... but it just didn’t seem to be there with Environmental Health.’ (HWB support officer ID30, site 4)

‘The Chartered Institute seems to have been quiet, and there are publications there, because they have produced publications because I’ve seen them. But they don’t seem to be ramming them down people’s throats like other people do. I think there’s been a lot of lobbying, and it doesn’t feel as if they’ve done as much lobbying.’ (HWB member ID11, site 2)

These observations tended to come from those with non-EH backgrounds working within the wider PH arena, perhaps as they had the benefit of noting how different occupations responded to challenges in the new system. It is unclear why similar views were not so widely expressed by EHPs and managers, although it could be due to differences in experiences and expectations of what professional bodies can achieve on behalf of their members.

9.7 Prioritisation of health and social care
As I have described in earlier chapters, the statutory HWB membership, wording of the HSCA12, and much of the literature and available guidance places an emphasis on health and social care, and this is reflected in the meeting agendas. Some interviewees felt that this emphasis on health and social care had overshadowed other functions with public health impacts;

‘..there’s a massive expectation that social care and the health world can get together and solve a load of efficiency savings and duplication... the implications for that for environmental health? It puts .. some of those environmental health things into, you know, ‘actually that’s not that important at the moment’. (EH manager ID34, site 7)

This suggestion is strongly supported by observational data, which shows health and social care issues dominating HWB agendas and meetings over a period of 18 months at all four case study sites, in particular local arrangements for integrated care. Site 1, for example,
held an additional meeting to host a nationally recognised speaker with a particular interest in integrated care. There was a strong feeling in subsequent meetings at this site that the messages of this speaker had been taken on board and that integrated care was a priority locally. An interviewee had recognised that EH was being overlooked, and appreciated health and social care as obvious HWB members (whether statutory or not), but was unclear why EH was invisible;

‘They [HWBs] probably naturally would select nurses and social workers and blah, blah, blah but what about environmental health? Why does this keep getting forgotten so much of the time? And I’m not quite sure why it is really.’ (EH practitioner and academic ID42)

Although, as I have described, there were many ideas put forward about why EH is invisible, EH practitioners and managers often could not understand why their role in tackling the social determinants of health was so unappreciated by others in the PH system.

9.8 Shouting louder
Many EH interviewees mentioned the need to ‘shout louder’ or ‘bang on the door’ to make their voices heard in the new PH system to improve their visibility;

‘I am Chair of the [area] Chief Officers Group and so within that group I know that there was some frustration by Local Authorities, trying to find a way in... but as Chair I was able to write to various different people within the old PCT structure and public health and just keep banging on the door and saying ‘look we’re here and you need us,’ (EH manager ID37, site 10)

This view was endorsed by HWB support officers, who had noticed an absence of EH door banging in some areas, often in contrast to other occupational groups, such as housing managers and pharmacists;

‘They’re not knocking on the door saying why haven’t we got a seat [on the HWB]... and whether the EHOs are happy that their districts are represented at the level below, at the [area] board, I don’t know, but I’d have expected them to be banging a lot harder on the door.’ (HWB member ID11, site 2)
This need for specialists to ‘be noisy and build alliances’ has also been noted by others commenting on the current state of PH in England (Lang and Rayner 2012 :4) and as discussed in chapter 1, it is possible that the absence of a university EH base or ‘home’ as a centre of excellence and platform to hold conferences and raise issues is a contributory factor in the invisibility phenomenon.

9.9 The future

There were serious concerns expressed by several people about the future of EH being under threat, being doubly invisible and under-recognised in the new PH system, coupled with the negative effects of LA spending cuts;

‘And in better financial times EHOs have been much more involved in terms of having much more health promotion type posts, but not being a statutory function, I think those tend to go when times get hard. So I don’t know, and I suppose my sense is environmental health sort of retrenches to statutory functions when finances are tight.’ (HWB member ID11, site 2)

Others felt that the new arrangements offered opportunities as well as threats;

‘My own view is, it’s, if you don’t embrace the opportunity, you are going to end up fighting with your existence in the not too distant future. So it’s about, you know, we haven’t got any choice and why would we want any choice actually, there’s an opportunity here, there’s an opportunity to make a real difference, let’s grasp this’ (EH manager ID47, site 18)

An interviewee added that they felt recognition was improving, but that it would be a slow process;

‘Environmental health practitioners are enormously powerful, it’s an enormously powerful role and you think about what you can do in people’s lives that no other profession, well other than perhaps acute medicine at that very urgent level can do, but when you think about the effect you could have on people’s home life particularly, it’s enormously, can be life changing- but it doesn’t seem to be recognised for that, so I think there needs to be more work in that area. But I do
think things are starting to shift, but it will be a long, uphill journey,’ (EH practitioner and academic ID42)

Others agreed, feeling that the opportunities are there, but some effort on the part of EH is needed too;

‘You know, do a bit of inward focusing, because I remember someone saying: you know, your ship may come in one day but sometimes you might just have to swim out a little to actually get it. And that’s what we’ve got to do. We’ve got to swim out a bit.’ (EH manager ID37, site 10)

There are mixed feelings about what the future looks like for EH, but there is a feeling that if visibility is to improve it will require significant effort on the part of EH practitioners, managers and at the national level to raise the profile with allied groups and HWB members.

9.10 Conclusion
This research strongly indicates that EH is suffering from double invisibility, in that PH is culturally invisible and within this EH is invisible. EH practitioners and managers expressed difficulties in promoting their service to HWB members, their allied occupational groups and elected members, and a variety of reasons were given for this. It appears that the exclusion of EH from the statutory list of HWB members has been unhelpful, in that health and social care issues have taken precedence and EH is seen as one amongst many other groups vying for HWB attention.

As I have described, this double invisibility is strongly felt by EH practitioners and managers, who consider their service vital in the new system. However this sense of importance does not appear to be shared by the majority of HWB members, support officers and other allied PH occupations, the former of which will be setting local health strategy.

There are mixed feelings as to whether this invisibility can be overcome in the new PH system, but many interviewees were making efforts to be heard by ‘shouting and knocking
on doors’ of others. There is a sense that efforts must be made to fight for a place, and some optimism that this will be possible, although the challenges and threats are significant.

**Chapter summary**

Environmental health appears to be doubly invisible, in that it is invivable within it’s ‘culturally invisible’ public health domain. Various suggestions have been made as to the reasons for this and on strategies for how invisibility could be overcome.

This chapter partly addresses research question 3 relating to the role of EH in tackling health inequalities, however the particular theme of ‘invisibility’ emerged during analysis of the data.
10 Environmental Health in the new Public Health system

This chapter discusses the historic role of environmental health (EH); what it means to be an EH practitioner (EHP); what makes EH distinctive; relationships with others in the new system; and the adaptation and flexibility needed to survive and grasp the opportunities available.

The changes to the English PH system have led to a period of reflection and adaptation of EH at practitioner, managerial and wider occupational levels. Initial hopes, seen in responses to the publication of the ‘Equity and Excellence’ White Paper (Department of Health 2010), were that there would be a secure place for EH in the new system (Chartered Institute of Environmental Health 2010). However, exclusion from the statutory HWB member list (as discussed in chapters 1 and 2) resulted in EH often being seen as ‘just another group’ lobbying for influence by many elected members and officers, as the following HWB member in a two-tier system alluded to during a wider discussion about HWB membership;

‘Getting them on the board is difficult because you can’t have them all on, so which one do you put on, which two do you put on... if you’re not careful the board gets too big.’ (HWB member ID10, site 2)

10.1 Historic context

As I have described in chapter 1, the history of EH is intertwined with medicine, but also rooted firmly in LG. This is something that many EHPs are acutely aware of, particularly in the light of the return of the PH function to LAs in April 2013, following its relocation to the NHS during the re-organisation of 1974 (Stewart, Bushell et al. 2003 :9). Several EH managers reflected on the historic context during interviews, noting the consistencies and variations in PH challenges over time;

‘Local Government was created out of the public health movement, the medical boards of health, the report from Chadwick, creation of district medical officers, boards of health, 1848, 1975 Public Health Acts took us on a path, that’s how local government was created, we were created to tackle the ... big health issues of the
day, now, I was going to say we haven’t got those issues now, but actually, they’re coming back, TB is coming back, Cholera is coming back, but we’re not dealing with adulterated food and poor sanitation and water issues, but we are dealing, now, with a whole range of new things, everything from increasing incidences of TB, food poverty, fuel poverty, overcrowding, homelessness...’ (EH manager ID41, site 12)

Shortly after the above interview, the ‘horsemeat scandal’ broke, where it was found that a significant number of processed meat products for sale in the UK had been contaminated with horsemeat (Wall 2013). Interestingly, the horsemeat issue has been linked to the historic role in dealing with food adulteration and contamination in discussion at several recent EH and trading standards conferences; perhaps seeking validation of the (historic and current) role of the regulation in PH during this uncertain time. In contrast to the historic validation of the current role, other interviewees referred to history in a more challenging manner, reflecting that past glories will not be enough to protect services today;

‘... you can’t just sit around and assume, because Edwin Chadwick and Snow did some good things a few hundred years ago, there’s a reason to carry on financing us. And that’s what I say to my guys. You know, your service costs X amount of hundred thousand pounds a year – what have you done for it this year?’ (EH manager ID37, site 10)

Others felt that the historic ability to change and adapt would stand EH in good stead;

‘.. we have always been flexible and adaptable and that’s got to be one thing that we’re looking at for the future. (EH manager ID35, site 8)

There are many concerns about the future of EH in the new English PH system, including a perceived need to ‘fight’ for a place in order to survive and flourish. Perhaps reflection on history and past achievements provides a sense of context and security for those concerned about their place in the new system. The challenges, suspected reasons for failing to thrive and ways in which the occupation is felt to need to adapt will be explored further below.
10.2 Difficulties in playing a full role

As I have described in chapter 4 on HWB structures, EHPs and managers have been largely unsuccessful in securing places as HWB members; they have, nevertheless, had some success in playing a role at the sub-structure level. Some interviewees expressed disappointment, whereas others felt that fighting for a place on the HWB should be not seen as the sole measure of success or influence in the new system;

‘.. I wouldn’t want to be on a Health and Wellbeing Board, if that was my only opportunity to influence anything. I’d consider that a failure.’ (EH practitioner with national role ID33)

Many interviewees expressed concerns about the relative lack of recognition and involvement of EH in the new PH and developing wellbeing systems and offered reasons for why this could be the case. Some interviewees focussed on their own personal shortcomings;

‘I feel I lack the background knowledge and the supportive evidence to make an impact at board level.’ (EH manager ID31, site 4)

Research findings associated with ‘evidence’ were discussed in detail in chapter 8.

Other interviewees felt that EH has lost its impact in recent years;

‘..I’ve worked with EHOs in districts where they seem to have a lot of clout, and it almost feels over the last few years that balance has changed somewhat.’ (HWB member ID11, site 2)

Reasons volunteered for this loss of clout included the narrowed scope and high level of specialisation of typical officers; as discussed in previous chapters, the nature of EH work has become increasingly technical and there are now few ‘generalist’ officers working in English LAs; the role tending to be retained only in very remote areas or in large cities such as Birmingham, where generalist officers are supported by specialist teams. The following interviewees considered this narrowing of focus, specialisation and loss of an holistic approach to be a limiting factor, when fulfilling a wider PH role. An EH manager blamed
this narrowing agenda on the qualifications and routes of entry, and had noted the impact of this approach in their own team;

‘...the training and the routes into the training have removed that need for a holistic approach to health, so we’re not as clearly defined as we used to be. If I look at my environmental health department here, I’ve probably got three environmental health officers in it. The rest are a specialist food manager, who is qualified to do high risk food inspections, but I couldn’t put them in a housing team, you know, when I was an EHO, you could plug me in anywhere, I would have struggled for a few days, maybe a few months, but I understood the connections and we’ve got staff who don’t understand the connections now.’ (EH manager ID41, site 12)(my emphasis)

A commentator has recently said ‘it’s time to reawaken the environmental health polymath, to bring our full skill-set to bear on local PH strategies and once again celebrate that being a specialist generalist is not an oxymoron- it’s what’s needed more than ever’ (MacAuthur 2013 :6). It would be interesting to carry out further research with other (public) health occupations which specialise, such as medicine, where the sense of identity and cohesion is perhaps stronger, even though their functions are equally varied; for example surgery and psychiatry are seemly as different as housing and food safety.

The location of EH practitioners in LAs was often considered important, in terms of department/directorate, physical place and also at the level of management representation. Several EH practitioners expressed a concern that the housing function being located in different departments (as it often is) has contributed to fragmentation;

‘... we’re all under the Environmental Director with the Leisure and the Public Healthy bit, and then the Housing Function sits under that, which they hate and they want to be back with us, because they’re EHOs. So they’re shipped off and you know, the problem is they’re led by a Planner and the Planner – obviously they’re not really interested in being helped by Environmental Health (laughs)’ (EH practitioner ID38, site 10)

Whereas others (very much the minority view) felt that this was less of an issue;
'for me Housing is very different anyway and maybe now my view, which might change, is perhaps that’s better with Housing Departments, because of the link with homelessness, with housing need, with area regeneration,' (EH practitioner and academic, ID42)

Several interviewees thought that management structures could be limiting to the local profile of EH, where it is represented only at lower levels of management;

‘we’re not getting environmental health officers getting up to that higher tier of management and therefore we are just another subsidiary of the other parts of engineering, that are part of his portfolio and no disrespect to [name], he is a nice guy, but he doesn’t know a lot of what we do, he knows that we do dogs, we have dogs coming out our ears, but everything else, he turns up and he doesn’t give a very good speech, because ... it’s not from the heart’ (EH practitioner ID24, site 4)

In a similar vein, others felt that EH practitioners were not fulfilling their potential in rising to senior management roles;

‘There’s probably 900 bloody accountants, aren’t there and lawyers, but actually we have to reinvent a role for EHOs within the things that will make a difference, and some of that is about common sense and pragmatism, you know- can manage people, can manage resources...we end up managing it, picking up the pieces around some of the behavioural stuff. But our skill set means that we could be the directors that manage the response.’ (HWB support officer ID8, site 2)

In some areas, HWB members reported an apparent apathy amongst EH managers and a failure to make the case for involvement, in comparison with other groups;

‘...I hadn’t really thought about it, but just talking with you about it and I’m thinking hang on, they’re key players and they’re not pushing like the sport and leisure people are pushing, and I don’t know why that is,’ (HWB member ID11, site 2)
A related observation from the same interviewee was that other groups were becoming relatively stronger in LG;

‘The chief housing officers feel like a much more powerful bunch of people than the chief EHOs.’ (HWB member ID11, site 2)

A small number of EH practitioners and managers have suggested arrogance and narrow-mindedness in EH could be an issue, the root of this being an assumption that the need for involvement is so obvious that the case need not be made;

‘I detect an arrogance and I was probably part of it, where people think everything is about environmental health, you name it, and we are the most important service that the council provides, a lot of people just don’t get that yet. There’s this pomposity and this arrogance that goes with environmental health that I come across so often - but actually, now I don’t do environmental health, I think, actually...I remember a chief executive who left a council I was in, saying to me once, ‘remember, [name], there’s more to life than environmental health!’ I’ve never forgotten that and he’s absolutely right...’ (EH manager ID41, site 12)

This research has found that there are many ideas about why EH is not playing a full role, including both internal and external factors; however, it has not been possible to identify whether any of these has a greater impact than others at local and national levels; or whether a combination of factors is contributing to a perceived failure to thrive or even a decline and fragmentation. This would be a fruitful area for further research.

10.3 Thinkers and doers

Many EH interviewees had given thought to what sets them apart from other PH groups and their conclusions fall into two broad themes; EH as ‘doers’; and the importance of the regulatory role. These are discussed below.

Very many EH practitioners and managers seem to see themselves as ‘doers’, as practical people who ‘get things done’ in comparison to their PH colleagues, who are thought to be more academic ‘thinkers’, lacking the skills to make things happen on the ground.

Differences between the players in the new English PH system were discussed in greater
depth in chapter 5, but the comment below gives an illustration of where EH practitioners feel their strengths lie, differentiating them from their colleagues;

‘At the moment we are trying to work together and obviously come to sort of some middle ground as to how we approach the project, but it’s very evident that they [PH colleagues] don’t really understand how to go out and interview people, and how to deal with people. I think they’re very good at dealing ... in numbers and...perhaps the bigger plan – but when it actually gets down to the nitty gritty about actually meeting these people on the street, I’m not sure, not convinced they’ve got the skills or the experience to do that and I think that’s really probably where we excel’ (EH practitioner ID38, site 10)

One interviewee recognised the strength of being ‘doers’ but acknowledged the weakness of failure to evaluate what has been ‘done’;

‘..we’re doers, we’re deliverers, but, perhaps, not great at evaluating what we’re doing and looking at the current state of play’. (EH manager ID31, site 4)

Others go a step further and identify where they feel ‘doer’ skills are necessary and will provide opportunities in the new system;

‘..those Health and Wellbeing Boards, need us...because they’ve got no foot soldiers... They’ve got no tools to actually do anything, so unless they engage us, they’ll never get anything done.’ (EH manager ID37, site 10)

This ability ‘to get things done’ has also been observed by others outside EH;

‘...the thing that’s really struck me, that those services, like, our Environmental Health Protection Service ... they do just make things happen quite quickly and quite fluidly and, I think, that’s something that we could really learn from on the broader agenda.’ (HWB support officer ID30, site 4)

Several interviewees felt that, whilst EHPs and their PH colleagues were different, they were able to, or could see the potential in trying to overcome these differences and work effectively together to play to their respective strengths;
‘So we’ve a practical view on things I think our public health colleagues have got a very evidence based and academic, I mean academic with a small a understanding of the health agenda and I think actually if we can combine that well we’d be a power, we’d be a massive power.’ (EH manager ID3, site 3)

One interviewee reported achieving a particularly good relationship between EH and PH;

‘...but I’ve got to say our public health colleagues have been very, very supportive of us’ (EH manager ID46, site 17)

Research findings relating to tensions between individuals and occupational groups were explored in chapter 5. Findings relating to how EH is seen, or not seen, by HWB members and others were discussed in chapter 9.

10.4 Regulation and enforcement
The enforcement, regulatory or statutory role was mentioned as both a positive and negative factor by EH interviewees. Viewed favourably, it was seen as something setting them apart- as something they fairly uniquely offer in PH;

‘... public health doctors, who are on high salaries, they’re very few and they are not going to get their hands dirty going to some grotty café so that people don’t smoke. So you get no enforcement. So we are really valuable. So, when people say to you, well aren’t you just the environmental policemen, well yeah, maybe at times we are. Maybe we need to be seen like that.’ (EH practitioner with national role ID33)

The interviewee went on to express their concerns that the role was very valuable, but was being lost;

‘What singles out environmental health? Well, I’ve always argued that it is that regulatory role that makes the difference...Now we are losing that. For me that’s the bit, the important bit that’s getting lost... The difference between the EHO working in a local authority and everybody else is that what I am telling you is underpinned by a legal requirement and expectation... and if I’m living in bad housing conditions, I don’t want somebody to come round and sympathise with me, and
differentiate the mould types. I want somebody to go and deal with my landlord.’

(EH practitioner with national role ID33)

A large number of interviewees agreed that the enforcement role was being lost, and did not see this as a positive development. They felt that the historic protections and respect given to EH as a statutory service carrying out routine proactive inspections can no longer be relied upon; meaning that new ways of working, defining and measuring the value of the role are required;

‘I think the days of having environmental health, where we’ve just fallen back on...
‘I don’t have to justify a reason; it’s statutory,’ doesn’t wash anymore.’ (EH manager ID36, site 9)

‘If I was a DPH and the Chief [environmental health] Officer came into me and I said ‘what can you do for my public health outcomes?’ and they said, ‘well we’ve inspected an awful lot of food premises this year’. I’d just say, ‘On your bike! On your bike, we’re not interested. Come back when you’ve got something useful to me,’ (EH practitioner with national role ID33)

Viewed more negatively, many interviewees observed that the reliance on statutory functions for protection historically has been limiting and that approaches need to change if EH is to thrive in the new PH system. One interviewee felt that this narrowed focus on target outputs had resulted in a potential loss of skills;

‘I almost feel that over the last ten years where everything got extremely target driven, people were at risk of becoming a bit de-skilled on project development and innovation and ...the innovative streak has been a bit cut out of it all, because it’s all been about targets’ (EH manager ID46, site 17)

An EH manager felt that the statutory regulatory role has resulted in an occupation which is not able to justify its role and place in the new system, compared to other occupational groups with medical backgrounds;

‘Environmental Health has never got itself properly aligned to ‘where is the scientific research to back it up?’ first thing the Medical Profession always does is
to say ‘this is the full evaluation of what that does, what the health impacts are and we know what the cost is to the NHS blah blah blah blah’ and when it comes to Environmental Health we say ‘it’s because we have to do inspections ‘cos the FSA [Food Standards Agency] tell us to’ (EH manager ID34, site 7)

This fits with the idea of EH as ‘doers’, rather than ‘thinkers’; the feeling that sufficient consideration has not been given to why certain activities are carried out, when following nationally set instructions on outputs, such as carrying out proactive routine inspections at a certain frequency;

‘In many ways we’ve been spoonfed it for years, because it’s been said, ‘That’s the problem, you need to go and inspect.’ ‘Okay, that’s what we’ll go out and do.’ And then we’ll go back next year, and we’ll do it again. But I think those days are gone, really. But we are in a transitionary period I think. (EH manager ID36, site 9)

The same EH manager went on to point out that an effective balance between statutory and non-statutory roles was not easy to strike;

‘..the other temptation, I guess... coming back to this current climate we’re in where it is much more evidence based, it is much less reliant on our statutory responsibilities. The temptation is to try and go for everything, but I think you could potentially spread yourself too thin. So it’s really trying to put your energies into those areas where you can have an impact and where you give benefit.’ (EH manager ID36, site 9)

These opinions were supported by the reflective view of another interviewee, who felt that the focus on enforcement had been distracting, resulting in a loss of understanding of wider impacts and benefits of EH work and the historic role of the occupation and its roots. Again, they felt that there had been a loss of the ability to ask why actions are taken and what the benefits are, and had not appreciated the impact of their role on wider PH outcomes;
‘when you look at the impacts you think, ah God, I wouldn’t have thought we impacted on that...[for example] noise nuisance- increased community cohesion, improved house prices, better business with more productive workers, and I was going ‘oh God no, I never even thought’ and I think that is a huge challenge... we’ve gone so far down the enforcement route and regulation that we forget what we’re there for, we forget what our roots are, that we forget that we were public health inspectors of old and we really are still dealing with the same problems. But we don’t make that connection.’ (EH manager ID1, site 3)

Several EH practitioners reported that some of their colleagues were finding it difficult to see a role for themselves outside regulation and enforcement, and what follows from this narrow approach could be a failure to grasp or engage with the wider PH role;

‘I think they still look at themselves as being regulators and there isn’t a law to say that you’re not allowed to eat 4 sausage rolls a day, you know. So I think a lot of them still think of themselves as regulators, I think a lot of them are scared of what public health actually means because we’ve not done public health, pure public health for such a long time.’ (EH practitioner ID24, site 4)

Another interviewee flagged up the related issue of the difficulty of building a career as an EH practitioner specialising in PH, and the likely direction of travel for the future;

‘They’re out there but they tend to move out of local government, they tend to go, you know, towards the HPA [Health Protection Agency, now Public Health England] or places like that because it’s ok to be part of the public health empire there, because that’s where it is...It will be alright in the future to say ‘yes, I do public health. I am part of the director of public health’s team’ but it will be a while before we get them there and before they feel safe with that,’ (EH practitioner with national role ID33)

Finally, it was notable that other interviewees, with non-EH backgrounds, viewed the regulatory role with more mixed, including more averse, feelings;
‘...when we interviewed for the director of public health .... a handful mentioned 
Environmental Health as a lever... so it was, often, a very powerful one, because 
you’ve got statutory, you know, responsibilities and ability to enforce... And it 
sounds a bit sinister, but, actually, if done correctly, can be a very positive way of 
having some changes.’ (HWB member ID5, site 3) (my emphasis)

Although many EH practitioners and managers felt that the statutory or enforcement 
function had in some ways been limiting, none expressed the view that it was in itself 
undesirable or sinister.

10.5 Effects of financial cuts
As I have described in chapter 1, this research was carried out in a period of ‘austerity’ and 
of substantial cuts in LG budgets which has had an impact on EH capacity locally in many 
areas. Several interviewees raised EH cuts as an issue in local service provision;

‘But they’re quite a crucial little service really that get hammered. Bit like trading 
standards here. They always get the first cut- bit like public art and stuff like that 
always gets first cut really.’ (HWB member ID21, site 1)

Others felt that the preventative role, being relatively inexpensive, would be protective as 
financial considerations were important when dealing with medical (including GP) and 
other colleagues in the new system;

‘...the way I explain it is the difference between preventative and curative health 
and, of course, as far as environmental health is concerned, it’s cheap and that’s 
good nowadays.. we prevent, we stop you being sick and a doctor cures you if you 
are unwell and the biggest issue around that, is there’s not enough money to cure 
everyone... so environmental health is the way forward, I think, and I kind of think 
that the doctors get that.’ (EH manager ID37, site 10)

One interviewee with a strategic role in a unitary authority noted the financial necessity for 
EH and their PH colleagues to work together in LAs;

‘... there is going to be a change in the way that Environmental Health operates 
with Public Health being incorporated into the Local Authority. Because there is a
substantial crossover between what they do and we can’t keep them as two complete siloed services, because we’ve got no money...’ (HWB Support Officer, ID6, site 3)

Finally, an EH manager raised concerns that they were not geared up to apply for funding (having relied on the statutory functions historically) and that skills would need to be developed to secure future services;

‘I think one of the big problems that I’ve seen in Environmental Health, is we’re not used to bidding for things, we’re not used to putting bids forward. If you get an FSA bid, or whatever else, it’s like, ‘Oh my God, what do I do with this?’ You know? And I think that’s something we’re going to have to get better at in the future.’ (EH manager ID36, site 9)

In many ways, this latter comment reinforces the view that the reliance on statutory functions has resulted in an EH workforce which is in many ways ill-prepared for life in the new PH system, where opportunities often lie outside the narrow regulatory role.

10.6 The future
Although EH practitioners and managers have clearly undergone a period of reflection and preparation for adaptation, their feelings were in many cases upbeat and positive about future opportunities and relationships with other occupational groups;

‘...once they know who you are, they are really interested, because it’s such an interesting career that we have, and it is important... but I think it’s exciting times and there’s loads of potential and I think if EHPs, especially if the ones with actual power, the higher ups, could actually start grabbing for and making a case’ (EH practitioner ID45, site 16)

Others felt some confidence in building upon their recent successes in securing funding;

‘Where there are opportunities out there no doubt people have just got to be prepared to fight for it and you know work at it and they’ll get there, we did didn’t we? We got there.’ (EH manager ID43, site 14)
Related to this was the felt need to share local successes nationally to cement the value of EH and to grow practitioner confidence in their PH role;

‘I think the issue is the EHOs getting the fact that perhaps there's an opportunity to re-shape what they do... so... the issue is, in each of the councils, the EHOs feel that they've got a relevance and that their work is relevant; and then trying to support sharing some of that around the county. ‘ (HWB support officer ID8, site 2)

It was also felt that EH needs to improve how it presents itself to others in the new system, both in evidencing an impact and also in how it communicates this impact;

‘I think we’ve got rusty skills but we can do the job and I think we’ve really got to increase our skills on PR, how we monitor things, how we show the impact of what we do, it’s going to be, for the moment they seem to be the crucial things... ‘ (EH manager ID1, site 3)

A DPH had a particularly good understanding of EH and the other regulatory occupations and intended to include them in future PH plans;

‘I think environmental health, trading standards, licensing as a group are real important elements of public health and we need to be working really closely with them. And I would see certainly [name] from trading standards and [name] from environmental health as part of that wider public health team.’ (HWB member ID26, site 4)

It appears that a number of EHPs and managers feel enthused about opportunities in the new system, and that some of this enthusiasm is shared by other groups. As one interviewee eloquently said, this is a time for reflection, adaptation and rebuilding, remembering that what has gone before is not necessarily good;

‘..we should be a little bit more humble and a little less arrogant about what we can do ‘for’ people, because we actually do ‘to’ people, don’t we? And it’s amazing what’s out there, so, you know, I’m glad it’s all falling apart and I’m glad that something better will be built from the ashes,’ (EH manager ID37, site 10)(my emphasis)
10.7 Conclusion

It is clear that recent policy changes have led to a period of reflection by EHPs and managers at all levels, particularly around issues of the historical context; what sets EH apart; and what is needed to adapt to and thrive in a new system.

There is a strong perception that EH is not playing as full a role as it could and should be. The possible reasons for this, as I have described, are many and varied and require further research, however, the predicament faced in EH is real and many interviewees expressed a desire to play a fuller role and have deployed a variety of strategies to achieve this. As we have seen, several interviewees felt positively that EH would be able to respond well and find a place in the new system, as it has done in the past, though others felt more negatively about the abilities and willingness of their colleagues to adapt.

Harrison and McDonald (2003:110-111) offer a helpful framework in trying to understand the EH position at a theoretical level, suggesting that there are two types of (medical) occupational model;

1. The Traditional model which emphasises interpretation, reflective practice which is informed by science, open communication between peers, pragmatism, and self-regulation; and
2. The Bureaucratised model which emphasises cumulative ‘evidence’, bureaucratised guidelines, external regulation, and considerations of cost-effectiveness

They note that medicine has moved from the Traditional to the Bureaucratised model and it appears that EH has not moved from the traditional model, which could help to explain tensions and the lack of recognition described in the findings of this research. They describe the change of medical practices in a way that rings very true to EH practitioners today;

‘. science has in the past provided a background that has informed the practice of clinical medicine, rather than an authororitative body of knowledge that has determined such practice. Thus much clinical practice has been ‘empirical’ (in the sense of based in trial and error) based on ‘tacit knowledge’ derived from the physicians personal experience and often described as an ‘art’ as much as a science...
it steadily became the conventional and academic wisdom that medicine ought to be more formally ‘evidence based’… ’(Harrison and McDonald 2003 :113)

As a graduate occupation, it seems that the majority of EH practitioners lose their academic connection and desire to question why at a deeper level, as they develop their careers, valuing the practical elements of the role. Efforts are being made by groups such as the EHRNet (Environmental Health Research Network) to encourage a reconnection with academia and to promote practitioner research and publication (Couch, Stewart et al. 2012). However this takes time and benefits will not be immediately felt and there is an urgent need for a research active academic ‘home’.

It is clear that it will not be possible to rely on past achievements, or the regulatory function to secure a future for EH in the new PH system and that a more sophisticated response is required to address this existential challenge, however as one HWB member put it;

‘...there’s a clue in the title that it [EH] has a role to play.’ (HWB member ID25, site 4)

The challenge for EH in 2014 and beyond is making it happen.

**Chapter summary**

Members of the environmental health profession have entered a period of reflection and adaptation in response to external policy changes, including consideration of their role, structures, functions and willingness to adapt to new challenges.

This chapter partly addresses question 3 relating to the role of EH, however the specific theme of the future of the profession emerged during analysis of the data.
11 Discussion and implications

This chapter discusses the main thematic research findings and their implications for policy and practice in relation to health inequalities; HWBs; the environmental health (EH) occupation; and for wider policy development. Harrison’s ‘design to doodle’ spectrum is also considered and provides an overarching conceptual framework in which to better understand the research. Finally, suggestions are made for future work which builds upon the findings of this project.

Whilst it should be borne in mind that this research took place during the early stages of HWB development and early functioning and therefore does not permit the evaluation of policy effects to be taken into account, it appears that HWB members and support officers, EH practitioners and managers generally have a shared commitment to tackling health inequalities in their local areas. However, the way that they might go about this task is somewhat unclear in many areas, particularly where the agenda has been dominated by health and social care issues and where the role of EH in tackling health inequalities generally appears to be ‘invisible’ to others in the PH system. The terminology and concepts around HWBs, wellbeing, and health inequalities are not clear and inevitably mean different things to different people. Nevertheless there is a general willingness and commitment to grasp the opportunities offered by the new structures and working relationships to impact the health of local populations. However, in the light of past initiatives and current financial constraints and deregulation, some participants were less optimistic, and were reluctant to predict success in tackling health inequalities at a population level as opposed to defined health issues or issues specific to small geographical areas.

11.1 Main findings

It is useful to consider the substantial findings in the context of the main overarching research questions. Each of these will be discussed in turn; the subsidiary questions described in chapter 2 contributed directly to answering the main questions and so are not listed individually here.

1. How will HWBs develop locally and what underlying issues can be identified?
It is clear that the policy of localism; the absence of central directives (with the exception of a statutory minimum membership list and the need to produce guidance on JSNAs and JHWBSs); pulling back and shrinking of the role of the state; and the encouragement of peer-support and local development of HWBs, has led to the development of a variety of HWBs with considerable variation in membership, sub-structures, meeting frequencies, practices and intentions. Previously, others have also found significant local variation in health policy enactment where central policy was lacking in detail (Coleman, Checkland et al. 2010). Some HWBs have retained a small membership, based primarily on the statutory list in the HSCA12; whilst others have included interested parties such as district and borough councils (in two-tier areas), providers, the police and the voluntary sector. All HWBs included in this research had included non-statutory members, but the number and backgrounds of these were mixed. There were, nevertheless, some similarities, for example in the creation of permanent ‘officer steering groups’ for agenda setting and action on HWB decisions and of ‘JSNA working groups’ or other ‘task and finish’ groups set up for a particular job or project and intended to be disbanded on completion of that task. At several sites, attention had been given to maintaining a balance between LA and health service members and at one case study site opposition elected members were invited to be HWB members, although it is unclear whether this would continue.

There were differences found in accessibility and the welcome given to members of the public, with some sites being more accessible than others during the developing pre-shadow and shadow stages. Some sites included meeting observers (generally people with a professional interest who were not HWB members, but were clearly known to them) in debate, whereas at others this was either seemingly not welcomed or permitted only in a very controlled way, and observers were kept physically at a distance from HWB members. In addition, the level of debate seen in public was mixed, with some sites actively ‘tweeting’ their discussion and considering live web streaming, whilst others had a clear policy of debating contentious issues away from the public gaze. This latter approach has some interesting implications for the idea of HWBs adding democracy to the health service, as residents would find it difficult to assess the contribution of their elected members to
debate and decision making on their behalf. The chairing styles also differed, with some allowing time for discussion of matters arising, whilst others were reluctant to allow new items, such as ‘any other business’ to be raised without prior agreement.

Routes of communication between HWBs and some occupational groups and district and borough councils (in two-tier areas) were also developing and were often informal, unclear and relied on existing personal relationships in many areas and Humphries et al (2012) have noted the additional challenges in two-tier areas, given their extra complexity. A variety of strategies were being employed by interested parties to try to influence and gain access to the HWB, for example the establishment of ‘local HWBs’ in some lower-tier areas (where the intention was to feed into the upper-level HWB debate) and also by attending meetings as observers, providing reports to HWBs, or securing places on HWB sub-structures. Strategies were generally constructive rather than adversarial, consistent with those used to influence health scrutiny committees as noted by Boyd and Coleman (2011). It was not possible to evaluate the success of these strategies at the early stage of HWB development during the research.

The new organisational structures and ways of working introduced by HWBs and the shift of PH to LAs has led to tensions between the different parties at personal, occupational and/or organisational levels; in many ways this is unsurprising as the different world views, practices and structures of NHS health care and LG are well documented (Glendinning 2002, Glasby, Dickinson et al. 2010, Staite and Miller 2011, Wilderspin 2013, Coleman, Checkland et al. 2014). Feelings of frustration and tension varied, but were in some places linked to the historic context; especially in two-tier areas between the County and District or Borough LAs where relationships had in some areas been previously troubled. In particular, some district and borough councils resented the ‘big brother’ attitudes of their upper tier colleagues. Some interviewees felt that tension was healthy and permitted frank debate and discussion and were concerned that immature relationships were ‘too polite’ and consequently restrictive. However, the ability to debate views in an atmosphere of mutual respect is quite different from working in an environment of snobbery, mistrust, misunderstanding or condescension as described by some interviewees. As an example, one
well-qualified, motivated and effective CCG interviewee had received such rough treatment during a HWB meeting that they did not continue in their role on the HWB.

There was a common view that the successes of HWBs so far have been in relationship building, and a commitment to continue this trend and to work more closely together was evident from people from all backgrounds. There was an excitement among HWB members about the opportunities offered by the new system, and this has also been expressed by others (Ellis, Curry et al. 2013). However some interviewees were more cynical about what would be possible to achieve in practice and history shows that health partnerships have generally delivered minimal outcomes (Perkins, Smith et al. 2010, Wilderspin 2013). Hunter and Perkins (2012) also caution against partnerships based on structures, suggesting that good relationships are more important for success.

The new relationships between LAs and GPs, (in the form of CCG representation on HWBs) were seen as offering new opportunities; however, mandated joint working at a time of upheaval, change and significant competing pressures, such as the PH shift, CCG authorisation, and LA (and other organisations) funding cuts have proved challenging, and Allen and Rowse (2013) have also noted the monetary and other issues faced. The significant demands of authorisation had on occasion limited the time and commitment of CCG members to HWB attendance and meaningful contribution, particularly during the pre-shadow and shadow stages and others have documented the practical difficulties faced by GPs in contributing (Tudor Jones 2013, Coleman, Checkland et al. 2014).

Observations of many HWB meetings showed a limited contribution of CCG members, beyond an update on their authorisation progress, particularly during the pre-shadow and shadow stages. In some areas poor CCG attendance was of such concern to the other HWB members that they formally raised the issue, for example at one case study site writing a letter to the CCG requesting that they improve their attendance and others have reported a lack of GP engagement (Tudor Jones 2013). During the development stages, there was some confusion around the role of the HWB in influencing CCG structures with HWBs taking very different approaches. There were also concerns about the ability of CCGs to manage their new responsibilities and to ensure that commissioning is in line with agreed local HWB priorities as reflected in the JHWBS.
2. Do HWBs tackle health inequalities and does this vary between areas?

There were differences in espousing and enactment in relation to health inequalities, particularly at sites where many HWB members were involved in the drafting of the JSNA and JHWBS in only a limited way. In many areas, due to the time and other competing pressures described above, the JSNA documents were merely ‘refreshed’ with further major re-drafting planned for the future. In some areas, this led to a loss of the feeling of ‘ownership’ by the HWB members of strategies produced in their name, and it is possible that this may have consequences for commissioning decisions.

There were also differing views on how measuring success, particularly in tackling health inequalities, would be achieved. During the research, HWBs were at different stages of development, but none had a firm idea of how they would determine their success in measurable terms. It was clear during observations that the main focus of HWB discussions was integrating health and social care, and tackling the social determinants of health received significantly less attention. Indeed, many of the social determinants, such as societal inequality and fiscal policy, are outside the core sphere of HWB members and their organisations and this was recognised by some interviewees.

There was a general enthusiasm for the Marmot objectives (Marmot 2010), as I have described in chapter 7, particularly on his policy objectives in relation to children, which was seen most strongly in the case study sites and has been reported by others (House of Commons Select Committee on Health. Communities and Local Government Committee 2013). There was generally a strong commitment to the prioritisation of children’s services across the sites. Marmot himself reports that ‘Now, over 75% of LAs have local strategies that are explicitly aiming to reduce health inequalities based on the recommendations I made in Fair Society, Healthy Lives’ (Marmot 2013 :4). However it is unclear whether he has also found that some priorities have been more popular than others as the data for this assertion is not provided, neither is it included by another source (Lockwood 2013) making similar claims. The findings from this research indicate that whilst in interviews there was generally a strong commitment to tackling health inequalities, in practice observations
showed that discussions during the pre-shadow and shadow stages predominantly focussed on health and social care integration, and CCG authorisation.

Many interviewees said that Marmot had provided a useful framework around which to operate, at a time when it was needed, which highlights the lack of detailed guidance available from other sources. Interestingly, none of the criticisms of Marmot made in the academic literature (Popay, Rogers et al. 1998, Pickett and Dorling 2010, Subramanyam, Kawachi et al. 2010, Whitehead and Popay 2010) were reflected in the views of interviewees. The commitment to Marmot was, however, less evident at some of the contextual sites, where a minority of interviewees felt that health inequalities were not given a high (or in some places any) priority.

As I have described earlier, health inequalities are ‘wicked’ issues, being complex and very difficult to address. This could perhaps be a reason for the apparent focus on other more straightforward issues; additionally there was great pressure on CCGs to gain their authorisation within a centrally set timescale, and there was a general feeling that investment in health and social care would save money in a reasonably short timeframe. In contrast, investment in health inequalities may not reap rewards for years, if not generations, and so is less attractive for prioritisation within the timeframes required for local politicians to demonstrate their impacts when campaigning for re-election.

3. **Is environmental health recognised as having a role in tackling health inequalities and how does this play out locally?**

It appears that EH is in a position of ‘double invisibility’, in that PH has been described as culturally invisible (Rayner and Lang 2012), and within this sphere, EH is invisible. EH practitioners and managers expressed difficulties in promoting their service to HWB members, their allied occupational groups and elected members, and a variety of reasons were given for this.

It appears that the exclusion of EH from the statutory list of HWB members has been unhelpful, in that health and social care issues have taken precedence and EH is seen as one
amongst many other groups vying for HWB attention. EH does not automatically have a ‘seat at the table’ in the new structure, and indeed the only EH manager in the research with HWB membership (site 3) lost this seat when the board was restructured back to almost the statutory minimum following local elections. The nature of HWB statutory membership and the inclusion of integrated care as part of the HWB role in the HSCA12 shifted the focus of discussion during meetings to health and social care matters, leaving little space for EH to contribute. In addition, in two-tier systems, where EH was represented by elected members often from another LA, routes of communication and the ability to influence agendas were often very limited.

It appears that the nature of policy and guidance on HWBs, notably lacking in detail and in the recognition of the existing LA PH role, compounded the ‘invisibility’ issue, as EH was not naturally included as part of the HWB structure. Nor was there a clear route to make the case for EH involvement, as was seen in the different strategies adopted; from setting up ‘local’ HWBs; to insisting on a place in sub-structures; to bypassing the HWB and working directly with the relocated PH teams.

It is well established that EH is a PH occupation, however for a variety of reasons as discussed in this thesis, it is often not seen or recognised as one, even within the health and PH communities. The occupational group with the strongest understanding of the role of EH was the DPHs, however this was patchy, and did not necessarily translate to being seen as equals with a strong role to play in tackling the social determinants of health. This contrasts with the recognition of EH as a PH occupation at national level by PH bodies.

There were also concerns that the regulatory role was diminishing and this is a view shared by other commentators (James, Tombs et al. 2013, MacAuthur 2013). EH practitioners generally felt that they have much to offer, including in tackling the social determinants of health, but were frustrated that this was often unrecognised by members of HWBs. However this was not true of all areas, as some have made an impact at sub-structure level and some DPHs showed a good understanding of the role and possible impact of EH. There were concerns that the consequences of invisibility would lead to the underfunding of services, particularly of non-statutory functions, in the future.
It is unclear whether EH will be able to overcome its ‘double invisibility’ and strategies for attempting to attract attention were described by several interviewees. This situation has led to a period of reflection and adaptation on the part of EH practitioners and managers and there was some optimism that it could be possible to play a fuller role tempered with concern about the willingness of some colleagues to adapt. It appears that the majority of EH practitioners lose their academic connection as they develop their careers at a practical level, seeing themselves a ‘doers’ rather than ‘thinkers’. There is a small groundswell of committed individuals attempting to reconnect EH with academia (Couch, Stewart et al. 2012), promoting practitioner research and publication in EH, and encouraging the building a strong evidence base. This will take time to impact and change established practices, and it is possible that the lack of an academic ‘home’ or centre of excellence in England could also be hindering for EH.

There was much talk of the need for ‘evidence’, and it is clear that the medical norm of EBP is now the expectation for all parties in the new PH system and the same requirement has been noted by others with respect to health promotion activities (Dunne, Scriven et al. 2012). LA occupations such as EH do not have a tradition of EBP, having been historically measured on numeric outputs, and this was commonly felt to be a disadvantage when attempting to demonstrate value, achieve recognition as a PH occupation, and secure funding for services. EHPs and managers generally recognised this and although they did not all see the value of EBP in itself, they did appreciate that following the approach was needed to play a full role in the new system. There were hopes in some areas that the combined skill sets of EH and PH practitioners would be complementary and much stronger if they work more closely together. Nevertheless EH was found to be largely ‘invisible’ in the new PH system, for example rarely featuring during discussions around areas in which they could have a role, such as housing. EH was not included on the statutory list of HWB members and only a very small number of EH managers have secured places on HWBs; indeed at one case study site EH (linked with housing) was represented at the shadow stage and then removed when the HWB went live.
11.2 The ‘design to doodle’ spectrum

As I have outlined in chapter 2, Harrison’s ‘Design to doodle?’ (Harrison 2011) provides a useful conceptual framework for understanding the findings of this research. The idea that different levels of detail and prescription had been given by different central government administrations stayed with me throughout my research and I have come to the view that the distinct lack of prescription and guidance offered by central government policymakers on the development of HWBs and the continued rise of the localism agenda coupled with overt political values, provided a natural update to the spectrum concept proposed by Harrison.

As I have described, the policy development and implementation for HWBs was carried out by local sites which were designated as ‘early implementers’. Harrison and Wood (1999) comment on the nature of these local actor ‘volunteers’ noting that they gain from their association with a successful project and avoid the negative outcomes of not participating. The findings from this research indicate that there was an enthusiasm for involvement, with one case study site in particular putting great emphasis on being seen as a national leader in HWB development. The engagement of local actors with the concept of HWBs led in most areas to their establishment well in advance of the passing of the HSCA12 and the deadline for going live.

Harrison and Wood (1999) define what a ‘bright idea’ is, listing four elements; the development of policy in secret; providing limited details of the policy; allowing for later policy development; and implementation by incentivised volunteers. In my view, all four elements are met by the process of introducing HWBs, and this is supported by the literature review and findings of this research. To illustrate, Murphy points out that there was no green paper on the proposals and ‘precious little forewarning of the proposed extent of the reforms from either the Conservative or Liberal Democrat election manifestos or from the coalition agreement’ (Murphy 2013 :250) and I have described previously the system of volunteer ‘early implementers’ and the lack of central government guidance available.

I argue that the blueprint for the introduction of HWBs was also ‘low’, given that there was very little guidance available during the development stage. I also take the design to doodle
spectrum one step further by linking the doodle or bright idea with the localism approach to HWB development seen during the research period. It appears to me that this new type of localism is the next step in the design to doodle spectrum, the difference being that of the inclusion of acknowledged political values; where the concept of decentralisation and localism has been actively promoted by the coalition government, in particular with the passing of the Localism Act in 2011, introducing a ‘general power of competence’ for LAs, (although this is coupled with a limiting ‘right to challenge’). Lowndes and Pratchett (2012 :22) have also noted the role of political values in a range of policies ‘...the Coalition’s reforms do show traces of an ideological commitment to localism and a new understanding of local self-government; there is an ideological agenda which has the potential to deliver a radically different form of local governance’.

On health and political values, Wilkinson points out, with reference to academics, that

‘health inequality has always attracted the attention of people interested in social justice. But, at the same time, we have always shrunk from the inherently political nature of what it implies. Rudolph Virchow reminded us that ‘medicine is politics and social medicine is politics writ large’...(Wilkinson 2006 :1229)

Virchow, a cell biologist who later became a politician, made these comments in 1848, and the issue of how involved PH practitioners and academics should be in politics remains an area of discussion and debate today (Mackenbach 2009). Very recently Bambra (2014) responded to criticism from the right-wing press to a paper she co-authored on the significant adverse health effects of the Thatcher era policies. It is clear that researching the contentious issues of health and politics, as this project has touched upon, is far from straightforward.

Returning to Murphy’s (2013) public management view of the introduction of HWBs, It appears to me that the development described by the three public management theories are compatible with Harrison’s spectrum in that they both describe a shift from a top-down or ‘design’ approach, via. a more complex and nuanced approach, where the design is less detailed and specific, and finally to a ‘doodle’ situation where there is an absence of central
or top-down specification and policy is made at a more local level where changes are made in response to local drivers and factors.

It is clear that this research has taken place in a policy context of localism as an espoused political value and, with the exception of a short list of statutory HWB members and the very open content of the HSCA12, there has been little attempt at prescribing local functions and structures. In drawing from the results of this research, it appears that the wide range of HWB structures, sub-structures, the level of local involvement of environmental health and HWB priorities are a direct result of the localism agenda which follows the doodle approach introduced by Harrison’s spectrum.

11.3 Implications for policy and practice

11.3.1 Health inequalities

As I have described, previous policies and initiatives to tackle health inequalities have met with mixed and patchy success and there are indications that HWBs may prove to be no different. This is unsurprising given their ‘wicked’ and complex nature. It appears that there have been significant missed opportunities in many areas, where a focus on health and social care issues has detracted from serious consideration of workable local actions to tackle the wider determinants of health. For example, there is potential to tackle air quality and transport issues; fuel poverty and public sector living wages; and educational achievements of both adults and children. However these matters rarely, if ever, featured in HWB discussions. In addition, many of wider determinants of health are outside the scope of core HWB members’ control and sphere of influence and knowledge, and ‘doodle’ and localism have led to policies which naturally differ at local levels.

This local variation presents something of a paradox, given that health inequalities are often geographical in nature. Even if each HWB is successful in reducing health inequalities in its own geographical area, there is no mechanism to address inequalities between HWB areas or at a national level.

The HSCA12 refers to the need to work with ‘health-related services’ and creative thinking about what these services could be, and wider relationship building will be required to make an impact; for example in reducing local unemployment, improving the local
environment and ensuring a good standard of living for all. Given these issues, it is difficult to envisage how a narrow focus on integrating health and social care will deliver significant (if any) improvements in health inequalities.

On a more positive note, HWBs given their novelty, their relatively positive welcome from the outset (compared to other measures introduced by the HSCA12), the high expectations of central government and local participants, and their perceived success so far in relationship building may offer a fresh opportunity to think creatively and to work across boundaries to improve the health of local populations.

Perhaps a way forward would be to develop workable strategies for the use of HWBs, as needed at local levels. There is some evidence that this has begun (Pickett, Melhuish et al. 2014), although sources are generally think-tanks and third sector organisations, rather than central government. A further option would be to encourage wider HWB networks for information sharing and support, and to develop strategies to address health inequalities between HWB areas nationally.

11.3.2 Health and Wellbeing Board wider context

During the research period it was seen that HWBs have spent much of their time during the early stages of development on health and social care matters, which is natural given their statutory membership and the emphasis on integrated care in the HSCA12. HWBs could potentially have a significant impact locally, where leadership is strong and all parties are willing to positively impact on the health of local populations. However, as I have described, many determinants of health are outside the scope of existing HWB members but there is an opportunity here for HWBs to use their influence on national policies which could have a significant impact. The introduction of local politics into health policymaking may lead to greater influence in party political policy and decision-making at a national level and there is a possibility that HWBs could impact on powerful factors such as wealth distribution, the introduction of a ‘living wage’, environmental issues, austerity politics, education policy, social housing policies and other policy spheres such as the North/ South divide and ethnic inequalities which significantly determine the health of local populations.
There is also a bleaker possibility that the introduction of local politicians and the short-term electoral cycle on which they are measured, may lead to a lack of commitment to longer-term initiatives that take time to yield positive results. In addition, the heightened role of local politics might possibly lead to political decisions on the role of individual responsibility, and moral judgements on the ‘deserving or undeserving poor’, or as in recent national rhetoric on the role of immigrants, in PH policymaking.

The promotion of localism and practice of ‘doodle’ facilitates the different development of local areas, which inevitably leads to local variation and a ‘postcode lottery’. As I have discussed earlier, with regard to refuse collection, central government has been known to respond to these local differences with central instruction and it would be interesting to continue to research this area as HWBs become established in the ‘live’ phase.

11.3.3 The environmental health occupation

If EH is to play a full role in the new PH system, and ultimately secure its future in England, practitioners and managers need to adopt a flexible attitude to their job roles and embrace the concept of evidence based practice. The success of EH as a PH occupation with a role in tackling the social determinants of health appears to be somewhat tied to that of HWB structures, policies, and their influence on local commissioning decisions. This is because remaining ‘doubly invisible’ is unlikely to prove to be an effective strategy for securing service funding in the future, where there are so many competing interests in an atmosphere of financial austerity and where the national drive is to reduce ‘burdens on business’ resulting in a reduction in the core regulatory role of EH. EH practitioners and managers must plan and evaluate their work, publishing results to demonstrate their impact on PH. This will necessitate reconnecting with academia and challenging the internal perception that they are ‘doers’ rather than ‘thinkers’. They will also need to develop relationships with health policymakers at local and regional levels and learn from other occupational groups, such as pharmacists and social housing providers, who appear to have made a greater impact at local levels.

11.3.4 Further development of policy

There are tensions between national and local policy, and national and LG, with a balance to be struck between national and local decision-making (and considering the much-
criticised ‘postcode lottery’ which emerges as a consequence of this). The policy of localism has placed greater power in the LG realm. However this has been coupled with financial cuts that in practice have limited flexibility in decision-making and funding decisions. It is unclear at this stage whether HWBs will strengthen local democratic systems, and there is a possibility that this will depend upon their willingness to engage directly with local people, including debating in public. In particular, if and when contentious decisions will need to be made, how local politicians react and are perceived could be important.

Others (Warwick-Giles forthcoming), have noted that central government has moved from a localism approach to a centralising and more prescriptive attitude with CCGs, where eventually a very rigid set of standards were imposed for central authorisation. This has been followed by close performance monitoring, which clearly contrasts with the findings of this research on the approach to HWB policy. It is possible that this contrast is related to the differences in budgets between CCGs (which are commissioners) and HWBs, which as I have discussed earlier rely on their influence, cannot compel action, and therefore are less politically ‘risky’. Perhaps this is also a reflection of the status of HWBs, and if this is the case, reinforces concerns that they will be little more than ‘talking shops’.

As I have discussed earlier, ‘doodle’ and localism will inevitably lead to local differences, where some areas will be more successful than others in impacting on the health of the local population. It would be interesting to follow up whether governments become more centralising and prescriptive towards HWBs if some areas are seen as being unsuccessful. Interestingly, Labour (Burnham 2013) have indicated that they would effectively switch the role of CCGs and HWBs, with CCGs taking an advisory role and if this does materialise, the policy landscape could change considerably.

Future policymakers will need to consider the health impacts of localising or centralising values in their decision-making, and their attitudes to regulation and ‘nudge’, particularly if progress is to be made in tackling health inequalities at a population level.
11.4 Future research questions

This research was carried out at a time of great upheaval and pressure when HWBs and CCGs were developing and rapidly changing and some of the data reflects a very fleeting period, particularly in sites where there were significant political leadership changes in the May 2012 local elections. It is important to follow up this research to understand how these findings from the very early stages of HWB development fit with organisations, structures, policies and practices when HWBs are better established and the PH transition has settled down.

In particular, there is a need to determine whether the hopes and aspirations of the national government and so many HWB members are realised and whether HWBs make an impact on local health and wellbeing in the medium-longer term. Suggested fruitful areas for further attention are listed below;

- Since many JSNAs and associated strategies were ‘refreshed’ during the shadow HWB phases, it would be useful to consider whether redrafted documents created during the more stable ‘live’ phase differ in substance and direction; in particular whether there is greater ownership from HWB members and if there is increased recognition of the social determinants of health during HWB meetings.

- Research would be useful in determining whether local commissioning decisions follow those priorities agreed in the JHWBS, and if not, why not. This would enable an assessment to be made on whether enactment in strategy is followed by enactment in practice.

- This research indicated an emphasis on consensus decision-making, whilst there were also tensions between various parties. Further research would be useful in looking at how these tensions play out over the longer-term, particularly where contentious decisions are made, for example the decommissioning of health care services which could prove electorally unpopular for local politicians. It is unclear how conflicts between HWBs and CCGs would be resolved in practice other than a
majority vote on the HWB, but given the limited influencing role, it would be useful to follow up how these decisions were made and acted upon, if at all.

- Linked to the above question is how the interface between HWBs and CCGs develops over time, as key individuals become better acquainted, and how this affects local decision-making and perhaps the willingness to disagree in public.

- It would be interesting to look at public perceptions of HWBs and the elected members sitting on them; whether attempts to engage the public are successful; and to explore how effectively local Healthwatch represents the views of local people in different areas.

- None of the HWBs included in this research had developed firm ideas on how their success would be measured and it would be very useful to follow this up. In addition, it would be interesting to discover whether the national PH outcomes framework plays a greater role in future HWB business. It would beneficial to consider the conclusions they come to around this and at a later stage to assess whether HWBs have been ‘successful’ in their own terms.

- It would be interesting to carry out further research on the views of others in the wider system, for example, planners, providers of leisure services, education, housing and those with an impact on the local economy and environment to ascertain how relationships have developed and their roles changed (if at all) since the introduction of HWBs.

- It was not possible to interview very many people with medical backgrounds for this project and a deeper exploration of their views on EBP and the preparedness of their LA PH colleagues in this respect would be an interesting area for further research.

- There is a strong perception that EH is not playing as full a role as it could and should be. Further research would be helpful in ascertaining if any of the strategies
adopted by EH practitioners to improve their visibility are successful in the
medium-longer term, and also whether there is a change in attitudes and adoption of
evidence based practice and if this has any impact on local prioritisation and
commissioning decisions and ultimately on the visibility of EH.

11.5 Reflexivity, strengths and weaknesses

11.5.1 Context of the project
At the time I accepted my PhD studentship there was no indication that major changes to
the healthcare and PH systems were in prospect, and my initial proposal focussed on the
role of partnerships between occupational groups and organisations in tackling health
inequalities in England. During the summer prior to my taking up the studentship, the
White Papers ‘Equity and Excellence: liberating the NHS’ (Department of Health 2010 a)
‘Healthy Lives, Healthy People: Our strategy for Public Health’ (Department of Health
2010 b) were published and this resulted in a substantial rethink of my research question.
Fortuitous timing enabled me to re-draft my proposal and the unpredicted consequences of
choosing to study a rapidly-changing area of importance to my peers will be discussed.

As I have described, the findings of this research indicate a lack of recognition and
engagement of EH in the new PH system; it has been difficult to remain objective about
this, as there are likely negative impacts on the future of an occupation in which I have
much invested. As Pellatt (2003 :32) describes feeling the emotions of ‘joy, pain, hurt,
excitement, anger, love, confusion, satisfaction, loss, happiness and sadness’ listed by
Coffey, this is also my experience. I have therefore made a conscious effort to analyse my
data as objectively as possible, regardless of how unpalatable and disappointing the
findings are to me personally and have used my supervisory team to test out and reduce
such potential bias.

11.5.2 Managing expectations
Perhaps as a consequence of researching a topical subject which involves my peers, I have
found that they often have high expectations of what my project can deliver. This is
illustrated by the comments of an EH manager during an interview;

Interviewee: ‘So what will come out of this, Surindar?’
SD: ‘*My PhD?’
I: ‘Yeah’
SD: ‘Hopefully lots of papers. That's the main thing, you know.’
I: ‘Yeah. So ... what conclusions do you think you're going to come up with, anything? Is it helpful to us, and how are you going to feed it into the world, so it's helpful to wellbeing boards?’ (EH manager ID8, site 2)

Researchers with no such occupational background do not have this added expectation and sense of obligation to publish practical results for their peers and many academics do not actively publish results of their research in this way; indeed some have even reported respondents having ‘difficulty in accepting that our prime aim was not necessarily to produce practical recommendations for action’ (Pollitt, Harrison et al. 1990 :182).

Managing these peer expectations and being clear about what my work may and may not achieve has been an unexpected challenge; it has been difficult at times to balance the expectations of my academic supervisors (who require a good PhD thesis submitted on time) with the expectations of my peers (who require something of practical value in a relevant timeframe). I am careful to remember that it is the generosity of these peers with their time and support that has made the EH strand of this project possible; whilst completing my PhD on-time is for my benefit too and was also linked to my studentship funding. Holloway and Biley (2011 :970) remind us that ‘Being a qualitative researcher means being accountable – for the choice of data and for their interpretations- to the participants and readers of the story.’

11.5.3 Publication
I have tried to use the feelings and expectations described above in a positive way to promote research and publication within EH and to share my early findings in ways which will be useful to practitioners, by writing opinion pieces for practitioner publications and speaking at conferences and seminars throughout the research period.

The dilemma of where and how to publish results will be familiar to any practitioner-researcher. The need to balance publication in highly regarded peer-reviewed journals, as required for a successful career in academia, against providing something of practical value
to the peers who have enabled the research to take place can be a challenge. Practitioner journals tend not to be peer-reviewed or so highly regarded in academia and require a different writing style to academic journals. In addition, peer-reviewed journals are currently not easily accessible to the majority of LA-based EHPs.

It is not possible to publish findings in a peer-reviewed journal that have been published elsewhere, as an element of originality is required. However, the peer-review process can be very slow, taking many months or even years from the submission of a paper to its eventual publication. Practitioners require information in a useable form in a timely manner; an issue particularly pertinent to this topical research project, given the rapidly changing environment. To wait until after peer-reviewed papers have been published to share potentially useful findings with my peers would render them of minimal practical value given the timescales involved.

I have actively shared useful early findings with EH practitioners where possible without compromising my ability to publish in peer-reviewed journals at a later stage. I have published opinion pieces in practitioner journals (e.g. Dhesi 2011, Dhesi 2012), contributed to four books for practitioners (e.g. Couch, Stewart et al. 2012, Dhesi 2013) and spoken at several conferences and workshops, including addressing two Public Health Ministers (e.g. Barratt and Dhesi 2011) (see appendix 6), although these activities are arguably of limited value when applying for academic posts and fellowships and must now be balanced with more peer-reviewed publications.

Viewed positively, publishing in two arenas reflects the recognition of practitioner-researcher work in different ways. In practice, publishing for two different audiences can require a significant additional time commitment, as academic posts traditionally do not recognise practitioner publications, and these are therefore often written only by those with the commitment and interest to give of their free time.

At the time of writing, there is an increased recognition in academia of the ‘impact’ value of work. This is becoming an established indicator for measuring the performance of academics and their institutions. It seems that the change could support the practitioner-
researcher who wishes to publish in a form useful to their peers, though it remains to be
seen how this concept will develop in practice and how quickly.

11.5.4 Transferable skills
EHPs possess many of the skills which are needed in qualitative research, such as
interviewing, taking statements, recording observations and critically analysing documents.
‘Softer’ skills such as the ability to communicate at a variety of levels, manage a complex
and challenging workload, and tenacity in arranging appointments have also proved
invaluable. Some (Chew-Graham, May et al. 2002) have pointed out that the power
relationships between occupational groups are different to those between professionals and
members of the public (in this case GPs) in the workplace, introducing a new interview
dynamic for the practitioner researcher. I have certainly noticed the difference in my status
from authorised EHP to student, for example, in the timing and response rate to emails and
requests for interviews.

The significant skills gaps I have encountered so far are in developing and applying theory
and in understanding and communicating in the language of academia. As Holloway and
Biley tell us

‘It isn’t easy to write a good story and to present a scholarly account.’ (2011 :970)

Indeed, they go on to highlight the difficulty that the ‘insider’ researcher can have in
looking beyond straightforward meanings to appreciate more abstract, theoretical ideas.

11.5.5 Summary
The practice of reflexivity and reflection on the impact of the researcher on their project is
known to be difficult (Finlay 2002), but is often described as both good scientific practice
and a valuable part of the qualitative research process (Mauthner and Doucet 2003, Wren
2004), provided it does not become merely ‘a self-indulgent form of navel-gazing’ (Carolan
2003 :13). I have found it a useful exercise in exploring and clarifying how my practitioner
background has impacted on each stage of this project, including the associated research
strengths and weakness.

It is clear that networks and organisations can provide a valuable means of recruiting
people to take part in EH research, providing the limitations of this method in terms of
potential bias are acknowledged, and where possible, countered. It follows that the qualitative EH researcher researching her peers must remain alert to the influence she could be having on her subjects and to explore this as part of the research process, including explicitly acknowledging her personal feeling and motivations and their possible impact on the research project and how the results are communicated. Having a supervisory team with non-EH backgrounds (e.g. academic GP, LA policy and research, academic) has helped me during this research, and it will be important to work within a mixed team in future.

The EH practitioner-researcher has a significant number of transferrable skills when utilising qualitative methods, although there are likely to be skills gaps which will require attention. In particular, it can be difficult to appreciate the wider theoretical and analytical contexts of research closely linked to one’s occupation, and to communicate in unfamiliar scholarly language.

Finally, there is a balance to be struck between pursuing a successful academic career, which entails publishing in peer-reviewed journals with the highest possible impact factor, and communicating findings in a way which will be useful to peers in technical publications. This can be challenging for researchers with practitioner backgrounds who wish to succeed in academic institutions, whilst producing information of practical value to their peers.

11.6 Concluding remarks

This research has covered three intertwined and overlapping areas or themes; HWBs, health inequalities and EH. Recent developments in these areas are linked by the policy approaches of ‘doodle’ and localism, including the shrinking of the state, and in particular the retreat of statutory and regulatory roles and the introduction of political values in policy making, shifting the focus to relationships, partnership-building, integration and the impact of individuals. The contexts in which the research has taken place, both at local and national levels, including austerity and budget cuts, major restructuring and high national and local expectations are all significant factors which have shaped the findings. Local PH arrangements have been found to be greatly varied and during this research they developed and changed considerably, as would be expected at a time of new policy development and implementation, and in the light of the ‘doodle’ and localism approach utilised.
The likely successes or failures in the three interlinked areas and how these successes and failures will be measured are as yet unclear. History indicates that partnerships deliver only minimal or patchy health improvements and it remains to be seen whether HWBs will break this trend with their new structures, lacking as they do any statutory authority. In the same way, health inequalities have proved intractable in the past and action on many of the social determinants of health is beyond the core sphere of HWB influence. In addition, where HWBs can readily play a role in tackling health inequalities, acting on local living and working conditions by engaging with EHPs, this does not appear to be happening; EH is seemingly invisible within its own PH community. HWBs generally do not appear to be aware of, or using all of the tools available to them and have often pursued a narrow focus on health and social care integration during their shadow development stages, whilst espousing a commitment to the Marmot principles, focussing especially on children.

Given that HWBs are to set the local strategic direction for health and wider wellbeing, from which funding decisions will flow, in many ways the focus on health and social care integration does not bode well for EH. It also appears that EH is at a disadvantage in that it does not have a tradition of evidence based practice, which is now the expectation for PH funding. Neither does it have a central academic ‘home’ from which to develop a research base and to equip EHPs and managers with the tools to thrive in the new system and there is a mixed picture around the willingness to adapt and respond.

There are, however some glimmers of hope in the optimism of those involved in re-building the PH system in England and their determination to make a difference to the health of people in their local areas, and in the success of some EH managers in securing funding for projects to tackle health inequalities.
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Appendix 1- Participant information sheet

Title of research project:
Exploring how Health and Wellbeing Boards are approaching the task of tackling health inequalities, with particular reference to the role of environmental health

Introduction

You are being invited to take part in a PhD research project on how Health and Wellbeing Boards (HWBs) are tackling health inequalities, with a focus on the role of environmental health. It is being conducted by a research student from the Health Policy, Politics and Organisation (HiPPO*) group at the University of Manchester. Before you decide whether to accept this invitation, it is important for you to understand why the research is taking place and what it will involve. Please take the time to read the following information, and feel free to discuss the study with colleagues if you wish.

*For further information on the HiPPO team, please refer to
http://www.medicine.manchester.ac.uk/primarycare/research/HiPPO/

What is the purpose of the study?

The purpose of the study is to investigate how HWBs propose to tackle health inequalities and whether or not a uniform approach will be adopted in tackling this problem. In addition, the study will also examine the factors that have influenced the approach(es) adopted in tackling inequalities, and the role, if any, of environmental health practitioners and managers in this area.

Why have you been chosen to participate?

You are being invited to take part in the study because of your involvement with and/or knowledge of a Health and Wellbeing Board.

What will I have to do if I choose to take part in the research?

As part of the study, it is intended to examine four shadow HWBs and each of their associated organisations. For example, these associated organisations might include Local Authorities, and Clinical Commissioning Groups, whichever is relevant to the setting up of the HWBs and their subsequent operation.

As the data collection methods will be qualitative, I am interested in observing meetings. During these meetings, I will record any observations made in writing as part of my research field notes, which I will then type up after the event.

In addition, I would also like to interview a variety of respondents (approximately 10-15) at each site. During these interviews, I will be exploring the following issues: the development and operation of the HWB; issues discussed by the HWB; any involvement of environmental health professionals; and other issues that arise as pertinent during the research. It is expected that each interview will last approximately an hour. To help me focus on your responses to my questions I
would like to audio-record the interviews with your permission and then write them up verbatim after the interview has taken place, so that I can analyse what you have said in more detail. Anonymised quotes from these interviews may be used in reports of the research.

Finally, I would also like to look at some of the background documents such as terms of reference and joint strategic needs assessments, along with documents specifically relating to the meetings observed (e.g. minutes, agendas etc). From this, I will then be better able to put all my findings together, in order to build a bigger picture of the development of these health and well being boards and how these have addressed health inequalities in particular.

**Do I have to take part?**

No, it is entirely up to you whether you participate or not. If you do not wish to participate, you do not need to give a reason, and there will be no adverse consequence for you as a result, neither will I be offended.

**Are any risks involved?**

No, there should be no personal risks to you as a consequence of taking part in this study; neither the interviews nor the observations are expected to cause any distress or discomfort.

**What are the benefits of taking part in this research?**

You will be able to use the study report to reflect on the approach of your HWB in relation to other HWBs. You will also contribute to an understanding of how HWBs are exploring tackling health inequalities and the role, if any, of environmental health practitioners and managers in this context.

**Will my data be kept confidential?**

All identifying features will be removed from any data so that no persons, organisations or groups will be named in any reports or publications that will be generated as part of this study, such as conference presentations, articles in academic journals and ultimately my PhD thesis. The final study report will be made freely available on the HiPPO website and participating organisations will be provided with a link. All the findings will be treated as completely confidential within the HiPPO research group (data will be shared within the team so that I can have my findings and ideas checked and verified as the project develops). All data will be securely stored in an anonymous format with codes attached to different organisations. This latter information will only be accessible to the HiPPO research group. All data stored on computers will be encrypted and any paper data will be stored in locked filing cabinets within locked offices for a maximum of 10 years in line with the University of Manchester data storage policy.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to me, the researcher Surindar Dhesi when I will do my best to answer your questions. If I am unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.
Who has reviewed this study?

The University of Manchester Research Ethics Committee has reviewed this study and given it a favourable opinion.

Contact for further information

If you have any queries about the study or would like more information, please contact:

Surindar Dhesi at surindar.dhesi@postgrad.manchester.ac.uk or on 0161 2752000

The project supervisors are Dr Anna Coleman – anna.coleman@manchester.ac.uk, Dr Kath Checkland – kath.checkland@manchester.ac.uk and Prof Stephen Harrison – stephen.harrison@manchester.ac.uk

Contact address: Health Policy, Politics and Organisation (HiPPO) Group, University of Manchester, 5th Floor Williamson Building, Oxford Road, Manchester M13 9PL Tel: 0161 275 2000.
Appendix 2- Consent form

Title of the project: Exploring how Health and Wellbeing Boards are approaching the task of tackling health inequalities, with particular reference to the role of environmental health

Name of principal researcher: Surindar Dhesi

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my or my organisation’s involvement in the project being affected in any way

3. I consent to being interviewed.
   I consent to the interview being recorded.
   I consent to the interview being transcribed

4. I agree to the use of anonymised quotations from interviews being reported in research reports, journal articles and presentations.

5. I understand that data collected during the study may be looked at by individuals from the University of Manchester and from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

6. I agree to take part in the above study

__________________  ______________  __________________
Name of Participant  Date  Signature

__________________  ______________  __________________
Researcher  Date  Signature

Please initial the box if you agree with the statement

Please complete both copies of the consent form (keeping one for your own records)
Appendix 3- Interview schedule for Health and Wellbeing Board members and support officers

‘Exploring how Health and Wellbeing Boards (HWBs) are approaching the task of tackling health inequalities, with particular reference to the role of environmental health’

Discuss with examples

1. **Person Profile**
   - Who are they, what is their job title? (day job)
   - What is their work history/occupational background?
   - How did they become involved in the HWB?
   - What is their role in relation to the HWB?
   - How is this role developing?
   - How would they like to see it develop?

2. **HWB Membership**
   - Who are and who do they consider should be members of the HWB?
   - What are the reasons for this?
   - How are the members interacting? (health and LA differences? Politics? Issues with size of board? Attendance / commitment of members?)

3. **HWB Development**
   - How do they see the HWB developing? (structure, membership, functions, role, authority)
   - Who is driving this direction locally?
   - How would they like to see the HWB developing? (any changes? sub-groups?)
   - Are they aware of how other HWBs are developing? (locally, around the country?)
   - What would a ‘successful’ HWB look like to them at the end of the shadow stage?
   - To date any claims to success of the HWB
   - To date what been major challenges / obstacles
   - Has the HWB set priorities for the next 12 months? (if so what are they and how were they set?)

4. **Health Inequalities**
   - What is their understanding of the role of the HWB in relation to health inequalities?
   - What definition of health inequalities is being used? (different definitions being used? What is the justification for this?)
   - How are health inequalities being assessed locally? (JSNA, Public health data etc)
   - What action (if any) is proposed to tackle health inequalities locally?
• Where is the proposed action focussed? (upstream or downstream?)
• How was this decided?
• How will success in tackling health inequalities be measured? (long and short-term measures/ use of proxy indicators?)

5. **Environmental Health (EH)**
   1. What do they understand that EH practitioners do?
   2. Are EH practitioners seen as having a role in tackling health inequalities locally?
   3. Are EH practitioners represented on the HWB? (Directly or indirectly?)
   4. What is their level of involvement in the work of the board?
   5. Does any role go beyond statutory duties?
   6. What are the reasons for involvement or non-involvement?

6. Anything further to add?
Appendix 4- Interview schedule for environmental health practitioners and managers

‘Exploring how Health and Wellbeing Boards (HWBs) are approaching the task of tackling health inequalities, with particular reference to the role of environmental health’

Note: background information on the composition and constitution of the case study HWBs will be gathered during an early meeting with key respondents at each of the sites. As a consequence, these issues do not form part of the interview schedule.

1. Person Profile
   • Who are they, what is their job title? (day job)
   • What is their work history/occupational background?
   • How did they become involved in the HWB?
   • What is their role in relation to the HWB?
   • How is this role developing?
   • How would they like to see it develop?

2. HWB Membership
   • Who are and who do they consider should be members of the HWB?
   • What are the reasons for this?
   • How are the members interacting? (health and LA differences? Issues with size of board?)

3. HWB Development
   • How do they see the HWB developing? (membership, functions, role, authority)
   • Who is driving this direction locally?
   • How would they like to see the HWB developing? (any changes? sub-groups?)
   • Are they aware of how other HWBs are developing? (locally, around the country?)
   • What would a ‘successful’ HWB look like to them at the end of the shadow stage?

4. Health Inequalities
   • What is their understanding of the role of the HWB in relation to health inequalities?
   • What definition of health inequalities is being used? What is the justification for this?
   • How are health inequalities being assessed locally?
   • What action is proposed to tackle health inequalities locally?
   • Where is the proposed action focussed? (upstream or downstream?)
• How was this decided?
• How will success in tackling health inequalities be measured? (long and short-term measures/ use of proxy indicators?)

5. **Environmental Health (EH)**

7. Does the HWB understand what EH practitioners do?
8. Are EH practitioners seen as having a role in tackling health inequalities?
9. Are EH practitioners represented on the HWB? (Directly or indirectly?)
10. What is their level of involvement in the work of the board?
11. Does any role go beyond statutory duties?
12. What are the reasons for involvement or non-involvement?
### Appendix 5- Coding descriptions (version 3)

<table>
<thead>
<tr>
<th>No</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Health inequalities- lifecourse approach</td>
<td>Any reference to the lifecourse approach in understanding and tackling health inequalities.</td>
</tr>
<tr>
<td>2.</td>
<td>Health Inequalities - Marmot</td>
<td>Any reference to Michael Marmot or the Marmot review in relation to health inequalities.</td>
</tr>
<tr>
<td>3.</td>
<td>Health Inequalities- social determinants/ wider determinants</td>
<td>Any reference to the social determinants or wider determinants of health in relation to health inequalities.</td>
</tr>
<tr>
<td>4.</td>
<td>Health Inequalities- resource allocation</td>
<td>Any reference to resource allocation, in health care or otherwise in relation to health inequalities or how they could be tackled.</td>
</tr>
<tr>
<td>5.</td>
<td>Health Inequalities- other</td>
<td>Any reference to health inequalities, whether causes or solutions not covered by the above.</td>
</tr>
<tr>
<td>6.</td>
<td>Medical model</td>
<td>References to the medical model of health, including discussions of service access and other medical factors as a means of addressing health inequalities.</td>
</tr>
<tr>
<td>7.</td>
<td>Social model</td>
<td>References to the social model of health, this includes the role of social workers.</td>
</tr>
<tr>
<td>8.</td>
<td>Environmental Health- food</td>
<td>Any references to the food safety / food hygiene / role of EH, including healthy eating/ healthy menu initiatives.</td>
</tr>
<tr>
<td>9.</td>
<td>Environmental Health - health and safety</td>
<td>Any references to the occupational health and safety role of EH.</td>
</tr>
<tr>
<td>10.</td>
<td>Environmental Health - private sector housing</td>
<td>Any references to the private sector housing role of EH, including HMOs, dealing with empty properties etc.</td>
</tr>
<tr>
<td>11.</td>
<td>Environmental Health - pollution control</td>
<td>Any references to the pollution control role of EH, including noise nuisance, air pollution and contaminated land.</td>
</tr>
<tr>
<td>12.</td>
<td>Environmental Health - as public health</td>
<td>Any references to the wider PH role of EH, including health promotion work and smokefree.</td>
</tr>
<tr>
<td>13.</td>
<td>Environmental Health - in context of tackling health inequalities</td>
<td>Any references to the role of EH in addressing the social determinants of health or mentioned in relation to tackling health inequalities.</td>
</tr>
<tr>
<td>14.</td>
<td>Environmental Health- as an occupation</td>
<td>Any reference to environmental health as a occupation, including direction, perceptions and impacts of the legislative changes</td>
</tr>
<tr>
<td>15.</td>
<td>Housing (social)</td>
<td>Any reference to social housing, whether council owned or housing association owned. Includes discussion of the decent homes standard.</td>
</tr>
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</tr>
<tr>
<td>16.</td>
<td>Board membership - membership creep</td>
<td>Any reference to increasing invited board membership and/or self appointment of additional members.</td>
</tr>
<tr>
<td>17.</td>
<td>Board membership - District/ borough council representation</td>
<td>Any reference to the role of or attendance of lower tier authorities in relation to the HWB.</td>
</tr>
<tr>
<td>18.</td>
<td>Board membership - representation of other non-statutory bodies (police etc)</td>
<td>Any reference to the role of or attendance of other non-statutory in relation to the HWB. (Statutory in this case refers to prescribed members of the HWB and not to the carrying out of statutory functions.)</td>
</tr>
<tr>
<td>19.</td>
<td>Constitutional matters- terms of reference</td>
<td>Any reference to the terms of reference of the HWB.</td>
</tr>
<tr>
<td>20.</td>
<td>Constitutional matters- reference to health scrutiny role</td>
<td>Any reference to the health scrutiny role of the LA, whether or not in relation to the work of the HWB.</td>
</tr>
<tr>
<td>21.</td>
<td>Constitutional matters- Role of DPH</td>
<td>Any reference to the role of the DPH, whether in the transition period or in the new system.</td>
</tr>
<tr>
<td>22.</td>
<td>Constitutional matters- PH transition arrangements</td>
<td>Any reference to the transitional arrangements for PH.</td>
</tr>
<tr>
<td>23.</td>
<td>Constitutional matters- other</td>
<td>Any constitutional matters not covered by the above.</td>
</tr>
<tr>
<td>24.</td>
<td>Decision making- conflict and tension</td>
<td>Any decisions made with apparent conflict and tension between parties.</td>
</tr>
<tr>
<td>26.</td>
<td>Decision making- prioritisation</td>
<td>Any decisions made in relation to prioritisation of plans or the work of the HWB.</td>
</tr>
<tr>
<td>27.</td>
<td>Politics- overtly political comments</td>
<td>Any overtly political comments made, whether by elected members, members of the board or others.</td>
</tr>
<tr>
<td>28.</td>
<td>Politics- individual responsibility</td>
<td>Any reference to individual responsibility as the solution for health related issues, whether or not made by elected members.</td>
</tr>
<tr>
<td>29.</td>
<td>Politics- collective responsibility</td>
<td>Any reference to collective or societal responsibility as the solution for health related issues, whether or not made by elected members.</td>
</tr>
<tr>
<td>30.</td>
<td>Politics- national steer</td>
<td>Any reference to national legislation, policy guidance or any other influencing factors originating at a national level. This code might overlap with the outcomes framework code.</td>
</tr>
<tr>
<td>31.</td>
<td>Politics- localism</td>
<td>Any reference to localism as a concept or local decision making.</td>
</tr>
<tr>
<td>32.</td>
<td>Historical context</td>
<td>Any reference to the historical context, whether seen as positive, negative or indifferent.</td>
</tr>
<tr>
<td>33.</td>
<td>Outputs- JSNA</td>
<td>Any reference to the JSNA or associated</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>34.</td>
<td>Outputs- JHWBS</td>
<td>Any reference to the JHWBS or associated documents and work groups.</td>
</tr>
<tr>
<td>35.</td>
<td>Outputs- commissioning</td>
<td>Any reference to commissioning, whether principles, decisions, policy or any other factor.</td>
</tr>
<tr>
<td>36.</td>
<td>Outputs- other</td>
<td>Any other outputs of the HWB not covered by the above.</td>
</tr>
<tr>
<td>37.</td>
<td>Outcomes framework</td>
<td>Any reference to the outcomes framework and outcomes in general. This code might overlap with the national steer code.</td>
</tr>
<tr>
<td>38.</td>
<td>Nudge</td>
<td>Any reference to the use of nudge as a behaviour change tool.</td>
</tr>
<tr>
<td>39.</td>
<td>Enforcement</td>
<td>Any reference to enforcement or regulation.</td>
</tr>
<tr>
<td>40.</td>
<td>Education – as a function of the LA</td>
<td>Any reference to education as a function of the LA, this could include educational attainment and PH work with schools.</td>
</tr>
<tr>
<td>41.</td>
<td>Education - as a PH tool</td>
<td>Any reference to education as a PH tool outside the school/college system.</td>
</tr>
<tr>
<td>42.</td>
<td>Relationships - with CCGs</td>
<td>Any reference to CCGs in relation to their work with the HWB.</td>
</tr>
<tr>
<td>43.</td>
<td>Relationships - with 2nd tier LAs</td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>Relationships - with other council committees</td>
<td>Any reference to other council committees or elected member functions outside the HWB.</td>
</tr>
<tr>
<td>45.</td>
<td>Relationships - with council officers</td>
<td>Any references to other council officers not attending or represented at the HWB.</td>
</tr>
<tr>
<td>46.</td>
<td>Relationships - with other occupational groups</td>
<td>Any reference to other occupational groups or individuals not attending or represented at the HWB.</td>
</tr>
<tr>
<td>47.</td>
<td>Relationships - with HealthWatch/Links</td>
<td>Any reference specifically to HealthWatch or Links.</td>
</tr>
<tr>
<td>48.</td>
<td>Relationships - with voluntary sector and the public</td>
<td>Any reference to the voluntary sector, including patient or public representatives not covered by the above code.</td>
</tr>
<tr>
<td>49.</td>
<td>Relationships - with businesses</td>
<td>Any reference to the business community or individuals.</td>
</tr>
<tr>
<td>50.</td>
<td>Issues between organisations</td>
<td>Any observation of or reference to differences between organisations represented on the HWB. This could include tensions or work done to overcome differences.</td>
</tr>
<tr>
<td>51.</td>
<td>Integrated care</td>
<td>Any reference to integrated care in relation to the work of the HWB.</td>
</tr>
<tr>
<td>52.</td>
<td>Conflicts of interest</td>
<td>Any reference to conflicts of interest or apparent conflict of interest, even if not articulated.</td>
</tr>
<tr>
<td>53.</td>
<td>Workplans</td>
<td>Any reference to the workplan of the HWB, whether being achieved or not.</td>
</tr>
<tr>
<td></td>
<td>Codes</td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>54.</td>
<td>Structures</td>
<td>Any reference to organisational structures, whether of the HWB or other associated organisations</td>
</tr>
<tr>
<td>55.</td>
<td>Public health- general</td>
<td>Any reference to PH, not covered by more specific codes</td>
</tr>
<tr>
<td>56.</td>
<td>Economic crisis and spending cuts</td>
<td>Any reference to the economic crisis, whether local or national and including current or future spending cuts</td>
</tr>
<tr>
<td>57.</td>
<td>Communication- public</td>
<td>Any reference to communication with the public</td>
</tr>
<tr>
<td>58.</td>
<td>Communication- external (not public)</td>
<td>Any reference to communication with external groups or individuals, but not to members of the public</td>
</tr>
<tr>
<td>59.</td>
<td>Communication – internal</td>
<td>Any reference to communication between HWB members and supporting staff</td>
</tr>
<tr>
<td>60.</td>
<td>Child- adult transition</td>
<td>Any reference to the transition from childhood to adulthood in terms of service delivery</td>
</tr>
<tr>
<td>61.</td>
<td>Reflexivity- role of researcher</td>
<td>Any reference to the role of the researcher</td>
</tr>
<tr>
<td>62.</td>
<td>Evidence</td>
<td>Any reference to evidence or evidence based practice or research and publication</td>
</tr>
<tr>
<td>63.</td>
<td>Board attendance- members</td>
<td>Any reference to the attendance at the board of board members</td>
</tr>
</tbody>
</table>
Appendix 6- Conferences and publications 2011-2014

Conferences

- Invited to speak at CIEH South West Region public health conference April 2014
- Invited to speak at CIEH 5+1 East Midlands public health conference March 2014
- Assisted in planning, spoke at, and ran a workshop for students with Dr Caroline Barratt at the CIEH Education and Research SIG research conference at the University of Wolverhampton in 2013 (invited). Event included a live link to the University of Kuala Lumpur.
- Spoke at the CIEH Beauty conference 2013 in London (invited)
- Presentation of early findings and leading of discussion at the CIEH Education and Research Special Interest Group meeting at the University of Birmingham 2013
- Spoke at the Health Policy and Politics Network academic conference at Oxford University on Environmental Health Invisibility 2013
- Spoke at the CIEH Education and Research Special Interest Group ‘Proving Our Worth’ Conference at the University of Teeside on ‘Developing your Research Skills’ 2013 (invited)
- Spoke at the University of Manchester Primary Care Seminar Series with PhD student Lynsey Warwick-Giles on our early research findings in January 2013 (invited)
- Presented on ‘Reading for Research’ with Dr Caroline Barratt at the EHRNet workshop held at Middlesex (2012) University and organised, hosted and spoke at a repeat of the workshop at the University of Manchester (2013)
- Presentation of early findings at CIEH Year Ahead Conference in Stratford upon Avon 2012 (invited)
- Presentation of early research findings to, and introduction of Anna Soubry, MP, Parliamentary Under Secretary for Health at CIEH Public Health Conference in London 2012 (invited)
- Presentation of early findings at the CIEH North East Region Public Health Summit 2012 (invited)
- Presentation to Anne Milton MP, Parliamentary Under Secretary for Health at CIEH Public Health Conference in London 2011 (invited)
Publications


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