The Association of Directors of Public Health
Integrated Care Systems Survey Report

Recommendations

1. **There should be co-terminosity between ICSs and LAs:** Co-terminosity with LAs would significantly ease collaboration and issues around democratic accountability. ICSs are by no means all 'local' with some spanning more than one region and there is potential for disconnect, particularly with the work on wider determinants.
2. **DsPH are an important voice on the boards/groups within an ICS, but the capacity of local authority public health teams impacts their contribution**: DsPH should be represented on their ICP and other boards/groups, but partners should be aware of the capacity constraints that DsPH work within.
3. **DsPH need more resources to support their work across both local government and their ICS:** DsPH are willing, wherever possible to support the work happening within their ICS but cannot do so without sufficient financial resource.
4. **ICS priority areas must translate into action and delivery:** ICSs must ensure that their priority areas are truly embedded across all their work and that there is a focus on evidence-based action and delivering change within these areas.
5. **Health inequalities work within ICSs should be joined up, strategic and focused on delivery:** ICSs must ensure that their health inequalities work is coordinated across the whole of the ICS and aligned with the local public health teams, including intelligence and population health work. This work should be strategic and focused on delivering outcomes for the local population.
6. **ICS infrastructure should not supersede local government infrastructure:** ICSs must ensure that the structures being built within their systems do not contradict or supersede those within local government. ICSs should jointly build their public health capacity with DsPH and ensure that they take into account the existing workforce challenges, act responsibly when creating positions, and play an active role in the long term sustainability of the workforce.
7. **All ICS partners should be understood, respected and sufficiently resourced:** With ICSs creating increasing demands on their partner organisations, it is important that smaller partners with less resources, such as local public health teams, are well respected understood and resourced. ICSs should ensure that the role of the DsPH and local public health teams is fully realised so that they can influence all the areas in which they have expertise.
8. **There should be a strong understanding of prevention with each ICS:** A clear definition of prevention within the ICS should be well understood by all partners (which outlines the distinction between primary, secondary and tertiary prevention). Not only should there be a clear commitment to increase spending on prevention (eg by 1% a year up to an aspirational target of 10-20%) but it should be used to achieve meaningful action and implementation.
9. **ICSs should do more to fully recognise the work of the voluntary and community sector:** Recognising and utilising the voluntary and community sector's understanding of the local population is an important component of improving the health and wellbeing.
10. **The strong partnership work that is happening between NHS organisations and local government public health organisations should continue:** The strong working relationship is a

really important part of the wider health and social care system. Public health teams in England moved from the NHS to local government in 2013 for the same reason that ICSs were created at a regional level. To ensure that organisations outside of traditional health services consider their impact on the health and wellbeing of the local population.

Introduction

Integrated care systems (ICSs) were formalised across England as legal entities with statutory powers and responsibilities in July 2022. ICSs consist of integrated care boards (ICBs) and integrated care partnerships (ICPs) in 42 regions across England (see annex 1 for the full list of ICS regions).

ICSs are partnerships that bring health and care organisations together to improve the health of the population in their local area, including Directors of Public Health (DsPH).

As with other system changes before it, DsPH and their teams have adapted and sought to collaborate with ICSs effectively for the benefit of the health and wellbeing of local populations.

In January and February 2024, we conducted a survey to investigate and understand the experiences of DsPH when engaging with ICSs (see annex 2 for the full questionnaire). In total, 54 DsPH completed the survey, representing 36 of the 42 ICS regions in England.

The responses shared below are grouped into the main sections of the survey and DsPH answers have been presented as a summary. Where appropriate, charts displaying quantitative findings have been included, or quotes which typify the collective DPH response.

Background

The regional response rate of our survey can be seen in figure 1. The most represented region was the North West (17% of total responses) and the least represented region was the North East (2% of total responses) [Question 2,5].

The majority of DsPH who responded to our survey only had one ICS in their local authority area (91%). A minority (9%) had multiple ICSs covering their area [Question 1].

The majority of ICSs covered more than one local authority (LA) area, with 91% of DsPH stating this was the case with their ICS. Only 9% of DsPH have one local authority present within their ICS. [Question 3,6].

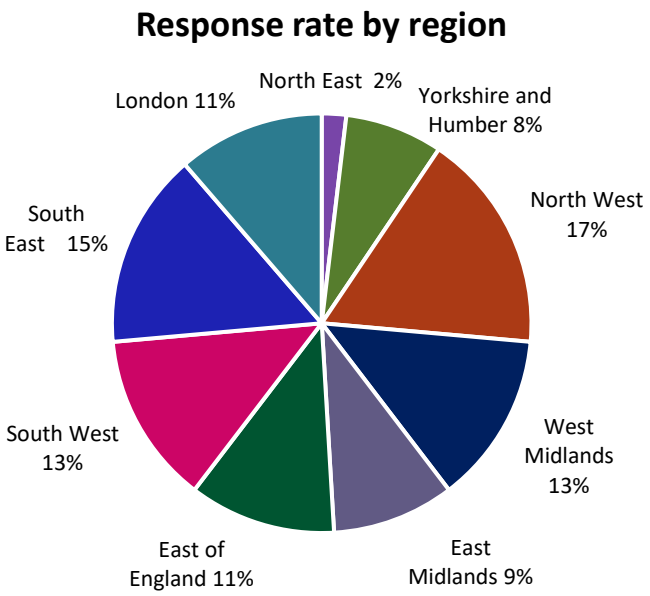

Figure 1: DsPH response by region [Question 2,5]

When there are multiple LAs within a single ICS, there are several ways in which DsPH divide the ICS

responsibilities [Question 8]. The most common way to divide the ICS work is for a DPH to lead on a specific area, for example if there are four ICS priority areas, one DPH will cover each of the four priorities. The second most common way to work is to share the topics. Meaning that instead of specific DPH leading on specific topics for the whole ICS region, DsPH cover all the topics and share work within each topic between themselves. In several regions, there was a combination of these two approaches depending on the work. In a small number of ICS regions, there is a DPH who leads across all the ICS work. However, one DPH highlighted that their ICS is moving away from this approach, as it wasn't an effective way of working.

Generally, how the responsibilities are divided is decided informally by DsPH and is relatively agile and flexible to interests/experience/capacity. A key theme in the responses was how positive the collaboration was amongst DsPH within the same ICS and that there was a good working relationship between LAs. Only two responses said that they had not yet established a way of working, or that they worked relatively independently. The lack of co-terminosity with LAs is still one of the biggest barriers to collaborative working within ICSs and this is of particular concern for the DsPH who have multiple ICSs covering their LA area. We recommend that where ICS boundaries are not coterminous with LA boundaries, they should be amended in order to minimise the potential for disconnect, particularly with ICS work on wider determinants.

How do multiple LAs divide the public health responsibilities across your ICS?

> "Each local authority leads on one or more ICS public health priorities, working in collaboration with the public health function of the ICB and other system partners."

Roles and responsibilities

DsPH are involved in a wide variety of boards and groups as part of their ICS work, with each DPH belonging to a list which is unique to them [Question 9]. Generally, Integrated Care Partnerships (ICPs) and Integrated Care Boards (ICBs) were the most commonly listed examples. Other examples included health and social care boards, health and wellbeing boards and population health boards.

Within each ICS there are many boards/groups that a DPH could potentially be involved with and each ICS has its own set unique to that region. Practically, this means that an individual DPH will struggle to be involved across every board/group and DsPH must be selective about where they provide input. As outlined in a previous section, if there are multiple DsPH in a region, often a DPH will lead on a specific area, to ensure that a local public health voice is present where possible. However, it can be a challenge, when local public health teams already have limited capacity, for DsPH to participate as much as they would like in the range of groups (see the next section on capacity). This is especially true for the DsPH who have multiple ICSs within their LA area or are the only DPH within their ICS.

The majority of DsPH felt they had good or very good representation in their ICP (figure 2). This is a positive signal that ICSs recognise the importance of having DsPH involved in developing the long-term strategy of the ICS. Over time, we hope that this figure will increase as the importance of the DPH input on local health and wellbeing at a strategic level continues to be recognised amongst the ICS partners.

In the case of ICBs, there was a much more mixed response. Some DsPH felt they had very good or good representation, but almost a quarter felt there was little or no representation (figure 3) [Question 10]. This largely reflects the role of the ICB as an NHS organisation which is responsible for planning health services therefore less closely aligns with the responsibilities of DsPH.

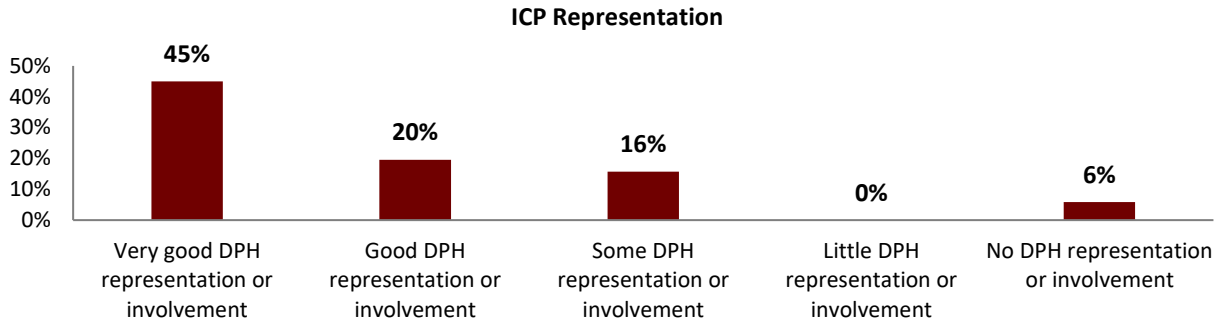

Figure 2: How well DsPH felt they were represented/involved in their ICP [Question 10]

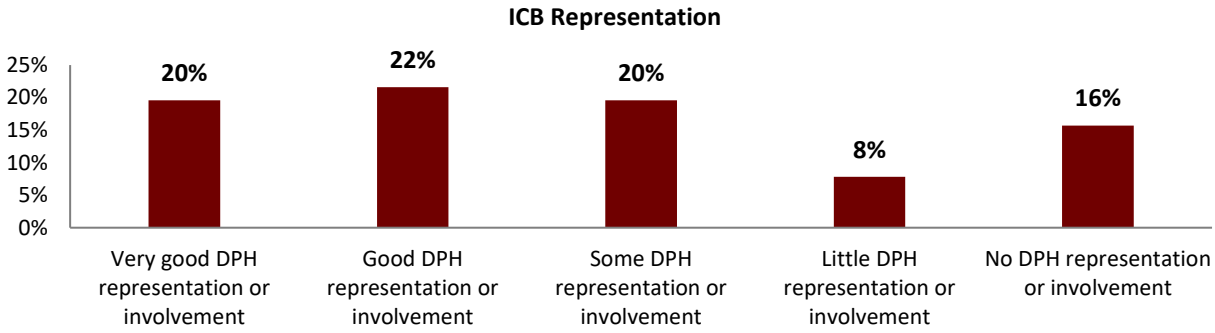

Figure 3: How well DsPH felt they were represented/involved in their ICB [Question 10]

Capacity

Whether DsPH felt they had the capacity within the public health team to be effective within their ICS is varied [Question 11]. The majority of respondents state that they have some or little capacity. Whilst only 16% state they have sufficient capacity and 4% of the respondents say they have no capacity at all (figure 4). This response largely reflects the increasing pressures on DsPH to work across both LAs and ICSs. Meanwhile they are dealing with the financial constraints of decreasing public health funding for local government and the associated challenge of insufficient capacity within local public health teams and workforce constraints. DsPH are willing, wherever possible to support the work happening within their ICS but cannot do so without sufficient capacity and resources.

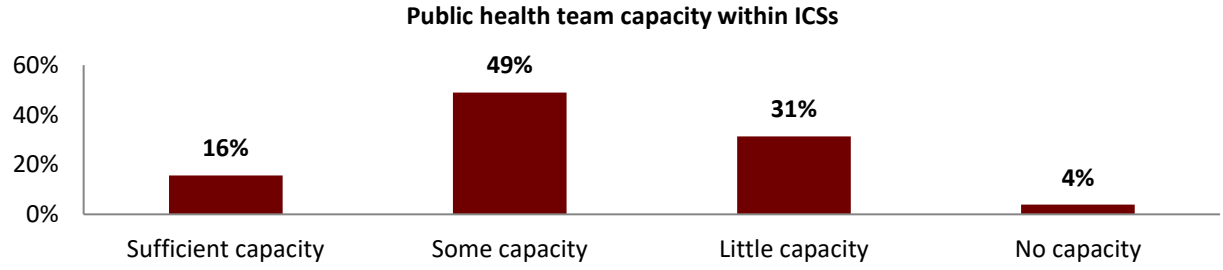

Figure 4: The extent to which DsPH felt their public health teams had capacity to be effective within their ICS [Question 11]

Clarity and consensus

The majority of DsPH (65%) felt that their ICS has shared objectives among all partners [Question 12]. ICS priorities generally focus on the life course or the wider determinants of health, with children and young people being a key focus area, alongside health inequalities, prevention, and mental health [Question 13]. The vast majority of DsPH knew what the priorities within their ICS were, with only a couple stating they did not. The general consensus was that being focused with fewer priorities enabled better delivery, and in ICSs where there were more than five priorities, DsPH were concerned about the resources available for delivery. When the priorities were very broad, there was also concern about being able to deliver across all the areas.

Most DsPH were happy with the priorities in their ICS, especially when they focused on the wider determinants of health. Depending on the ICS, there were sometimes topics that DsPH felt should have been a priority, for example climate change or health protection. The biggest challenge associated with the priorities was that it wasn't clear what action was needed to deliver on the priorities. Or that despite these being the priority areas, this wasn't reflected in the delivery. Some DsPH raised concerns about the priorities only being viewed through the lens of secondary prevention and treatment services or the lack of resources available for delivery. ICSs must ensure that their priority areas are focussed and embedded and that there is clear evidence-based action for delivering change within these areas. It is also vital that there is a firm understanding of what delivering on a priority means beyond the lens of health services.

What are the priorities in your ICS? Do you feel as DPH there are any priorities missing?

> "I am happy with priorities. Some concerns re the resource and whether we always have the right staff focussed on the issues where they have the relevant expertise and influence to bring about change. For example councils are much better placed to lead on issues such as housing."

Health inequalities

There were five key ways in which DsPH identified their ICSs are addressing health inequalities: priorities, boards, strategies, reviews and specific funding pots [Question 14]. Those who previously mentioned that health inequalities were a key priority for the ICS stated that this meant the ICS considered it in all its workstreams. A quarter of DsPH mentioned that their ICS had one or more boards that guided their ICS on health inequalities, such as Population Health Improvement Boards or Prevention and Inequalities Boards. Some DsPH specifically referred to a strategy to address health inequalities that were either developed or being developed. Some DsPH mentioned specific health inequality reviews that had been conducted to identify areas for change. Finally, a few DsPH mentioned specific ICS funding for health inequalities within their ICS.

Within their responses, DsPH generally stated directly or indirectly that there was a large quantity of work happening within their ICS on health inequalities. Many referred to the 'Core 20 + 5' programme and the joint working happening within their ICS. Some highlighted despite there being a lot of work under the umbrella of health inequalities, not all of it was coordinated and it could be quite piecemeal. Many highlighted that there were opportunities for more joined up practice, considering the existing work and expertise of DsPH and their local teams. Others highlighted that although in principle there was agreement

to focus on health inequalities, this wasn't always the case in practice or there were no actions outlined on how to deliver. We recommend that ICSs ensure that their health inequalities work is strategic and coordinated across all the ICS partners including local public health teams. There is existing expertise on and experience with health inequalities work within LA teams that should not be dismissed by the ICSs. We also suggest that as ICSs continue to mature as systems, the focus on delivery should be a key component of their development, to ensure the work that has happened over the past two years produces a tangible impact.

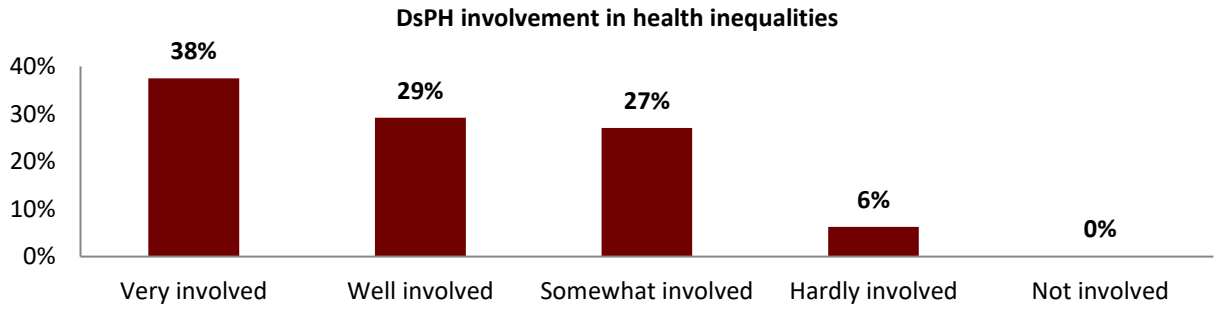

Figure 5: How involved DsPH are in driving the health inequalities agenda within their ICS [Question 15]

The majority of DsPH felt they were well involved or very involved in driving the health inequalities agenda within their ICS, only 6% felt they were hardly involved and no DsPH felt they were not involved at all (figure 5) [Question 15]. The strong involvement of DsPH in the ICS health inequalities work across the regions demonstrates there is a good understanding of the knowledge that DsPH and local public health teams have in this area. As ICSs continue to improve their ways of working we would hope to see more DsPH would describe themselves as being well or very well involved.

How is your ICS addressing health inequalities?

> "Reducing inequalities is a priority for the ICS… the ICB commissioned a specific review on health inequalities post-covid…with significant community engagement and co-production, and this has identified specific areas for change (such as translation) as well as broader themes for longer term action".

Infrastructure

83% of DsPH responded that their ICS had its own population health infrastructure, separate from the local government public health infrastructure [Question 16]. Most DsPH felt their team was well or somewhat connected with the ICS population health team, with no DsPH stating there was no collaboration between

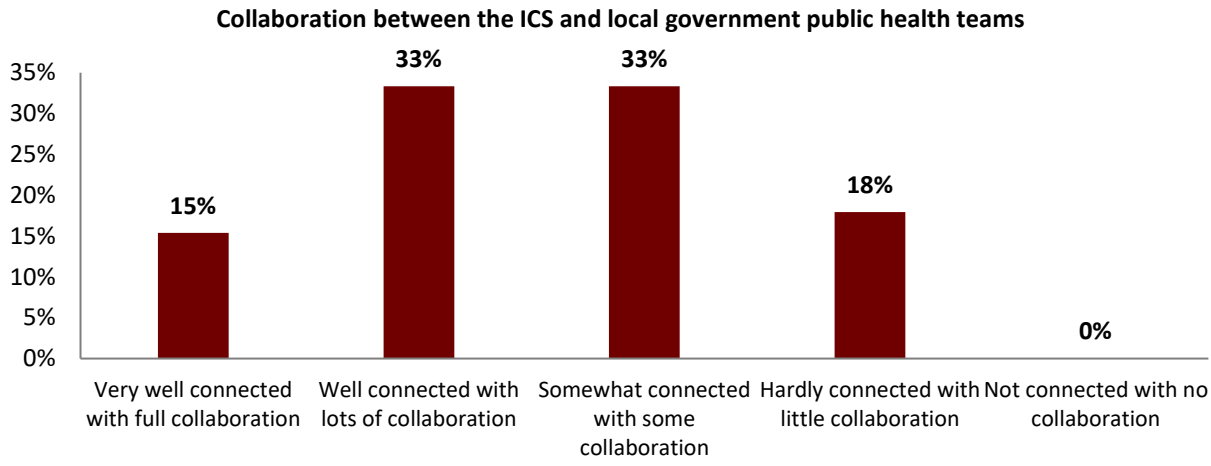

Figure 6: The extent to which DsPH felt their ICS population health team connected and collaborated with their local government public health team [Question 17]

the teams (figure 6) [Question 17]. As a third of DsPH feel their local government public health team are only somewhat connected with their ICS public health team, we recommend that increasing the amount of joined-up working should be a key focus area for ICSs moving forward. With so many areas having separate infrastructure, it's vital to ensure there is no duplication of the work completed within the two separate teams within one locality. There is a wealth of knowledge contained within the local public health team and ICS public health teams can gain from this expertise through collaborative working.

As previously mentioned, the issue of workforce capacity continues to be a challenge within the public health system. Therefore it is important that when ICSs are developing their public health workforce, they take into account the existing workforce challenges, act responsibly when creating positions, and play an active role in the long term sustainability of the workforce.

Collaboration

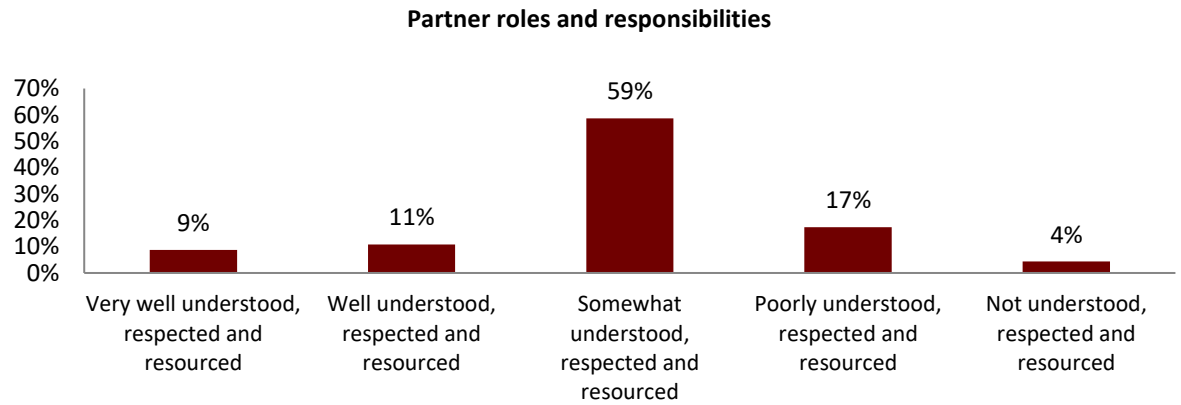

Figure 7: The extent to which DsPH feel that the roles and responsibilities of all partners are understood, respected and resourced in their ICS [Question 18]

The majority of DsPH (59%) feel that the roles and responsibilities of partners are somewhat understood,

respected, and resourced in their ICS (figure 7) [Question 18]. This indicates that more can be done to improve the understanding of partner roles and responsibilities within the ICS. It is especially important for smaller partners with less resources, such as local public health teams so that they can maximise their strategic insight and provide expertise where most appropriate within their ICSs.

Generally, DsPH feel that they have some influence within their ICS [Question 19] but that there is room for improvement. Several DsPH mentioned that they are building a relationship, and this process is still ongoing. In some areas they are invited to lead whereas in other areas they are still overlooked. For example, one DPH stated it was easier to influence health inequalities than screening and immunisation. There was a general sentiment that to influence you must be proactive and present, which is not always possible for DsPH who are already struggling with capacity constraints. Many also highlighted how it is difficult to get the PH function settled correctly and felt that it was included as an afterthought or there was a danger of superficial representation or 'tokenism'. Many acknowledged the significant financial pressures that impact their ability to fulfil their commitments. We recommend that ICSs should ensure that the role of the DsPH and local public health teams are fully understood so that they are able to influence across all the areas in which they have expertise. Public health representation should not be considered secondary to other organisations. Most importantly the financial context in which public health teams operate must be improved so that they can provide a voice for local public health within local government and ICSs.

Do you feel that LA public health has appropriate influence within your ICS?

"It's patchy. We tend to be influential in some areas of business and less so in others".

Prevention

DsPH feel they see some or little commitment from their ICS to increase spend on prevention (figure 8) [Question 20]. Some DsPH felt that were was no commitment at all (7%).

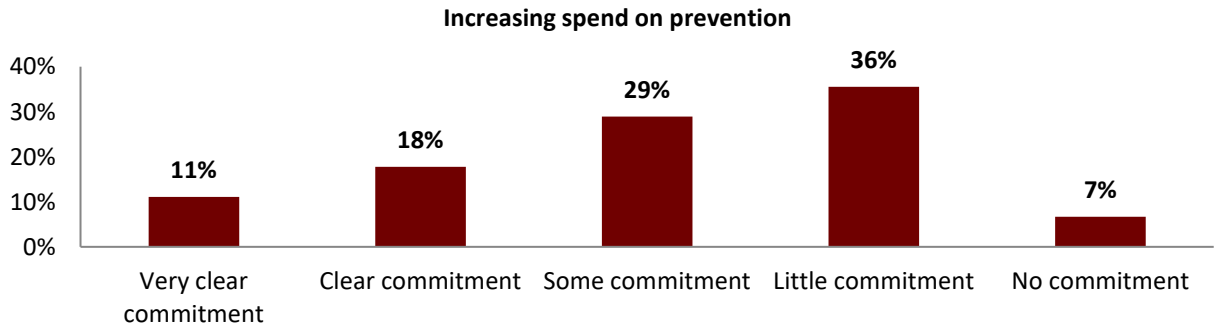

Figure 8: The extent to which DsPH can see a clear commitment from their ICS to increase spend on prevention [Question 20]

DsPH thought that although there was a commitment in principle to supporting prevention within ICSs, this wasn't always demonstrated in practice [Question 21]. The largest obstacle was the lack of budget and how this meant although there was a commitment in theory, this wasn't always reflected in action. DsPH felt that the term prevention was used a lot within the ICS, but this was a catch all term and realistically, a focus on prevention translated into things such as system savings, reducing hospital flow, or preparing for

winter pressures. Some DsPH felt that the situation was improving in their ICS, but the majority felt there was still a way to go to achieve a meaningful impact. We recommend that all partners understand what prevention means in its entirety and that sufficient resource is allocated towards meaningful action and implementation. It is also crucial that even in areas where prevention spend has increased, it should continue to do so, and this should be the case across all the ICS regions. The Hewitt Review into Integrated Care Systems recommended an increased spend on prevention of at least 1% over the next five years, and we recommend that this should increase to an aspirational target of 10-20%.

How effectively do you think your ICS covers prevention?

> "The intention is good and there are pockets of good practice, but we've yet to embed a clear direction of travel or strategy covering primary and secondary prevention effectively. The importance and cost effectiveness of prevention is well understood, but this is not translating in practice…"

Existing structure and local assets

The majority of DsPH (62%) felt their ICS partially recognised and built on the infrastructure and work of the voluntary sector and other local partners. No DsPH felt that the contribution wasn't recognised at all (figure 9) [Question 22]. As the majority of DsPH felt this recognition was partial, we recommend that ICSs should do more to fully recognise the work of the voluntary and community sector. There are many benefits in collaborating with these organisations, which DsPH already do in their LA roles to great effect. Recognising and utilising the voluntary and community sector's understanding of the local population is an important component of improving health and wellbeing.

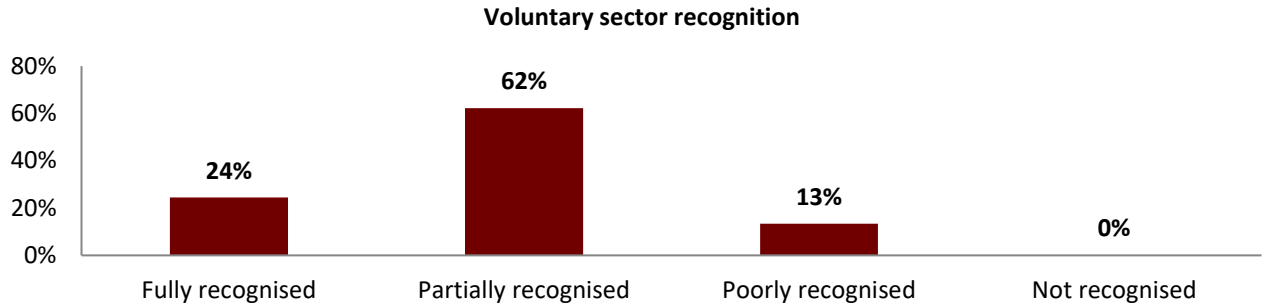

Figure 9: The extent to which DsPH felt their ICS recognised and built on the infrastructure and work of the voluntary sector and other local partners, including those beyond health and care [Question 22]

NHS Public Health workforce

58% of DsPH have joint posts with their local NHS or strong links with public health personnel employed locally and regionally [Question 23]. Throughout their responses, DsPH that have joint posts referred to a strong working relationship across public health and NHS organisations [Question 24]. Many referred to Directors of Population Health (NHS posts) with whom they worked closely. Many also mentioned consultants in public health who sit within their ICS.

Other examples of joint posts include a shared intelligence unit funded by the NHS and led by the LA PH team and a partnership commissioning team for children's and adult's services which is shared between the NHS and LAs with a management group which has rotating chairs from both organisations.

The strong working relationship between the NHS and public health organisations outlined by some DsPH is an important part of the wider health and social care system which should continue to be reinforced in areas where it already exists. The success of these posts and the benefits of collaboration mean there is already a strong blueprint for similar roles in other areas of the country in the future.

There is a risk that by the NHS developing Directors of Population Health positions and employing consultants in public health, the existing public health workforce challenges will be exacerbated further. One DPH specifically told us in their response that they were concerned about the consultant positions within their local NHS trusts, as consultant level workforce recruitment and retention is a significant challenge in their local area. Public health teams in England moved from the NHS to LAs in 2013 and there is a solid evidence for public health teams being based in local government, as outlined in The Kings Fund Assessment of English local government public health reforms. NHS and local government public health teams must be not in competition for resources within a region as both play an important role in the health and wellbeing of the local population.

Please could you provide a brief description of any joint posts, including whether these are joint with NHSE or NHS Trusts, and/or how you maintain strong links with the NHS?

> "Our ICB has a public health consultant employed as a permanent post. This post does not formally report to any DsPH but there is a strong collaborative culture with local authorities."

Additional Comments

When DsPH were invited to share any additional comments, these generally fell into the categories of the ICS structure, ICS leadership, the public health system, public health funding, and good practice.

Many DsPH discussed their ICS structure in their final comments. One commented how the ICB and LA boundaries need to be coterminous for integration to work effectively. Another expressed their view that the entire ICS structure is an NHS construct and the focus on ICSs misunderstands the local reality. One DPH stated there was ongoing confusion regarding ICS/ICP/ICB in terms of layers of governance in their area. Several DsPH responses contained the idea that ICSs are still in their infancy and their structure is still within the development process.

Are there any other comments you would like to share?

> "We work as ever at the boundaries of NHS/LA to make things work irrespective of the national and regional duplication of the public health/NHS system and local politics. This takes endless patience and resilience."

Separate from the ICS structure, DsPH highlighted ICS leadership within several of their comments. This included the challenge of being granted involvement in leadership decisions and achieving wider influence within an ICS. Some DsPH acknowledged there are LA/NHS politics which influence opportunities for public health within the ICS and that the role of public health is very dependent on the relationships held by the DsPH. There was concern around how the leadership was often dictated by the NHS, however one DPH noted that 'in reality without an element of dictation, nothing happens at all'.

In terms of the public health system more generally, there were concerns about the fragmentation of public health and the issues that arise as a result. The increasing role of population health within the NHS

has a serious risk of creating division and fragmentation between the NHS and LA public health teams. In addition, the rise in demand for public health professionals within the NHS is creating workforce and recruitment challenges for LAs.

Many DsPH mentioned funding challenges and the impact of NHS cuts in their ICS. One DPH highlighted the need for health inequalities funding to be used appropriately, and another shared that a large sum of investment had recently been withdrawn from public health. One DPH highlighted that a commitment from the NHS to fund prevention interventions would be useful.

Finally, several DPH wanted to emphasise the positive working relationships they had. One DPH stated a joint post was working brilliantly. Another (quoted below) was keen that the good practice that happening in some areas was acknowledged. One DPH stated they had a successful blueprint for collaborative public health engagement in their ICS, coproduced by DsPH and the ICB and ICP to invest in prevention and would be keen to share this with other DsPH.

Are there any other comments you would like to share?

> "Keen that anything that comes out reflects the strength of our working and relationships with our ICB… lots of good practice to build on which I would not like to see undermined."

Conclusion

DsPH and their teams are committed to participating in the strategic work of ICSs, despite their capacity constraints, and have worked collaboratively not only with the other LAs within their ICS but with other partner organisations as well. The enthusiasm of DsPH to ensure the system works effectively is clear, but there are practical constraints to the level of input DsPH can provide. Especially in the context of fragmentation across the English public health system, and the funding cuts to the LA funding.

The key theme throughout the responses is that these systems, which are less than two years old, are still maturing. Part of this maturing process involves embedding an ICS's priorities within all of its work in a meaningful way and ensuring it is focused on evidence-based action and delivery. It is not enough to state that there is 'prevention work' happening within an ICS unless all partners have a clear understanding of what is meant by the term 'prevention' and that there is sufficient investment in it. Another part of the system maturing is ensuring that all ICS partners understand the wider landscape of health and wellbeing, and are familiar with the statutory role of DsPH as well as the knowledge that exists already within LA public health teams. LA teams have existing expertise in a range of ICS areas, including health protection, screening and immunisation, and health inequalities. ICS partners should also increase their understanding of the role of the voluntary and community sector.

It is important that as the systems mature, the infrastructure that is created within ICSs does not duplicate or supersede the infrastructure within LAs. Joint posts between the NHS and LAs enhance partnership working, and the links between the organisations should be strengthened, to reduce the risk of fragmentation. However, the responsibilities of public health teams in local government mustn't be diminished or replicated in parallel within either the NHS or ICS infrastructure.

Annex 1
ICS Regions across England

ICSs have been established as follows:

- North East and Yorkshire
- North West
- Midlands
- East of England
- South West
- South East
- London

North East and Yorkshire

- Humber and North Yorkshire
- North East and North Cumbria
- South Yorkshire
- West Yorkshire

North West

- Cheshire and Merseyside
- Greater Manchester
- Lancashire and South Cumbria

Midlands

- Birmingham and Solihull
- Black Country
- Coventry and Warwickshire
- Derby and Derbyshire
- Herefordshire and Worcestershire
- Leicester, Leicestershire and Rutland
- Lincolnshire
- Northamptonshire
- Nottingham and Nottinghamshire
- Shropshire, Telford and Wrekin
- Staffordshire and Stoke on Trent

East of England

- Bedfordshire, Luton and Milton Keynes
- Cambridgeshire and Peterborough
- Hertfordshire and West Essex
- Mid and South Essex
- Norfolk and Waveney

- Suffolk and North East Essex

South West

- Bath and North East Somerset, Swindon and Wiltshire
- Bristol, North Somerset and South Gloucestershire
- Cornwall and the Isles of Scilly
- Devon
- Dorset
- Gloucestershire
- Somerset

South East

- Buckinghamshire, Oxfordshire and Berkshire West
- Frimley
- Hampshire and the Isle of Wight
- Kent and Medway
- Surrey Heartlands
- Sussex

London

- North Central London
- North East London
- North West London
- South East London
- South West London

Annex 2
ICS Questionnaire

Background

*** 1. Does your area have more than one ICS?**

- ◯ Yes
- ◯ No

Background: single ICS

*** 2. Which ICS covers your area?**

*** 3. Does your ICS cut across multiple local authorities (LAs)?**

- ◯ Yes
- ◯ No

Background: multiple ICSs

*** 4. Which ICSs span your area? (Select all that apply)**

- ☐ Humber and North Yorkshire
- ☐ North East and North Cumbria
- ☐ South Yorkshire
- ☐ West Yorkshire
- ☐ Cheshire and Merseyside
- ☐ Greater Manchester
- ☐ Lancashire and South Cumbria
- ☐ Birmingham and Solihull
- ☐ Black Country
- ☐ Coventry and Warwickshire
- ☐ Derby and Derbyshire
- ☐ Herefordshire and Worcestershire
- ☐ Leicester, Leicestershire and Rutland
- ☐ Lincolnshire
- ☐ Northamptonshire
- ☐ Nottingham and Nottinghamshire
- ☐ Shropshire, Telford and Wrekin
- ☐ Staffordshire and Stoke on Trent
- ☐ Bedfordshire, Luton and Milton Keynes
- ☐ Cambridgeshire and Peterborough
- ☐ Hertfordshire and West Essex
- ☐ Mid and South Essex
- ☐ Norfolk and Waveney
- ☐ Suffolk and North East Essex
- ☐ Bath and North East Somerset, Swindon and Wiltshire
- ☐ Bristol, North Somerset and South Gloucestershire
- ☐ Cornwall and the Isles of Scilly
- ☐ Devon
- ☐ Dorset
- ☐ Gloucestershire
- ☐ Somerset
- ☐ Buckinghamshire, Oxfordshire and Berkshire West
- ☐ Frimley
- ☐ Hampshire and the Isle of Wight
- ☐ Kent and Medway
- ☐ Surrey Heartlands
- ☐ Sussex
- ☐ North Central London
- ☐ North East London
- ☐ North West London
- ☐ South East London
- ☐ South West London

*** 5. Of the multiple ICSs in your area, please select one that you would most like to answer the remainder of the questions about.**

*** 6. Does your ICS cut across multiple local authorities (LAs)?**

- ◯ Yes
- ◯ No

Background: multiple LAs

*** 7. Which other LAs are part of your ICS?**

8. How do multiple LAs divide the public health responsibilities across your ICS?

Roles and responsibilities

9. Which boards and groups do you feed into as a DPH?

10. To what extent is there DPH representation on the Integrated Care Partnership and Integrated Care Board within your ICS?

	Integrated Care Partnership	Integrated Care Board
Very good DPH representation or involvement	○	○
Good DPH representation or involvement	○	○
Some DPH representation or involvement	○	○
Little DPH representation or involvement	○	○
No DPH representation or involvement	○	○

Capacity

11. To what extent do you feel you have the capacity within your public health team to be effective within your ICS?

- ◯ Sufficient capacity
- ◯ Some capacity
- ◯ Little capacity
- ◯ No capacity

Clarity and consensus

12. To what extent do you feel your ICS has shared objectives amongst all partners?

- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly disagree

13. What are the priorities in your ICS? Do you feel as DPH there are any priorities missing?

Health inequalities

14. How is your ICS addressing health inequalities?

15. To what extent are you playing a key role in driving the health inequalities agenda?

- ◯ Very involved
- ◯ Well involved
- ◯ Somewhat involved
- ◯ Hardly involved
- ◯ Not involved

Infrastructure

16. Does the ICS you feed into have its own population health infrastructure, separate from the local government public health infrastructure?

- ◯ Yes
- ◯ No

17. To what extent does your ICS population health team connect and collaborate with your local government public health team?

- ◯ Very well connected with full collaboration
- ◯ Well connected with lots of collaboration
- ◯ Somewhat connected with some collaboration
- ◯ Hardly connected with little collaboration
- ◯ Not connected with no collaboration

Collaboration

18. To what extent do you feel that the roles and responsibilities of all partners are understood, respected and resourced in your ICS?

- ◯ Very well understood, respected and resourced
- ◯ Well understood, respected and resourced
- ◯ Somewhat understood, respected and resourced
- ◯ Poorly understood, respected and resourced
- ◯ Not understood, respected and resourced

19. Do you feel that LA public health has appropriate influence within your ICS?

Prevention

20. To what extent can you see a clear commitment from your ICS to increase spend on prevention?

- ◯ Very clear commitment
- ◯ Clear commitment
- ◯ Some commitment
- ◯ Little commitment
- ◯ No commitment

21. How effectively do you think your ICS covers prevention?

Existing structures and local assets

22. To what extent does your ICS recognise and build on the infrastructure and work of the voluntary sector and other local partners, including those beyond health and care?

- ◯ Fully recognised
- ◯ Partially recognised
- ◯ Poorly recognised
- ◯ Not recognised

NHS public health workforce

23. Do you have any joint posts with the local NHS or strong links with public health personnel employed locally and regionally by the NHS?

- ◯ Yes
- ◯ No

24. Please could you provide a brief description of the joint posts, including whether these are joint with NHSE or NHS Trusts, and/or how you maintain strong links with the NHS?

Final comments

25. Are there any other comments you would like to share?

Region

Please note, we will collate responses to present a summary representing the collective voice of DsPH. No individual will be named in our report.

The information provided below is for internal purposes to ensure sufficient regional coverage across England.

*** 26. Your region**