Are health and well-being strategies in England fit for purpose? A thematic content analysis

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ABSTRACT

Background Since 1 April 2013, local authority (LA) health and well-being boards (HWBs) in England are required to publish a health and well-being strategy (HWS). HWSs should identify how population health needs are to be addressed. The extent to which this has been achieved is not known. We analysed HWSs to assess how LAs have interpreted statutory guidance, how evidence has been used within HWSs and the relationship of HWSs to Joint Strategic Needs Assessments (JSNAs).

Methods Qualitative thematic content analysis of a random sample of one-third of upper tier LA HWSs in 2013–14.

Results Fifty out of 152 LAs were sampled and 47 HWSs analysed. Strategies varied in timescale, length and structure. The term ‘evidence’ was used most commonly referring to local need, rather than evidence of effectiveness. All, except two, referred to JSNAs.

Conclusions HWSs are dominated by evidence of need and could be strengthened by greater use of evidence of effectiveness for public health interventions. Public health agencies and academics can support the development of effective HWSs by improving the accessibility of evidence and conducting research when evidence is absent. To strengthen HWSs’ impact, the statutory guidance should clarify the distinction between evidence of need and evidence of effectiveness.

Keywords management and policy, organizations, public health

Background

When the Health and Social Care Act 2012 came into force on 1 April 2013 in England, some public health staff transferred from the NHS to local authorities (LAs) and Health and Wellbeing Boards (HWBs) were established to bring leaders from across the health system together to focus on improving population health.¹ It is expected that HWBs will reduce health inequalities and integrate services.² Since 2007,³ LAs and the former Primary Care Trusts (NHS organizations) had produced Joint Strategic Needs Assessments (JSNAs) whose purpose was to identify a population’s key health needs so that services could be commissioned to address those needs. This requirement remains and now HWBs are also required to produce a new document called a health and well-being strategy (HWS)⁴ to address ‘the needs identified in Joint Strategic Needs Assessments (JSNAs)’ (p. 8) and to ‘translate JSNA findings into clear outcomes the board wants to achieve, which will inform local commissioning—leading to locally led initiatives that meet those outcomes and address the needs’⁵ (p. 9). The House of Commons Communities and Local Government Committee sees the HWS, in conjunction with the JSNA, as instrumental to the success of the new public health structures,⁶ viewing them as ‘living, breathing documents to which all local health partners willingly contribute and adhere’ (p. 77, vol. 1). While HWSs are expected to set out strategic intent, a range of other instruments and processes, such as commissioning plans, play key roles in the translation of strategy into concrete action. Expectations of

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the content of HWSs are framed by the statutory guidance and commonly accepted strategy standards. A well-founded strategy is considered to identify the long-term direction of an organization. It is often defined as the means by which an organization’s objectives and actions are outlined. Although it is expected that there will be variability in HWSs, national guidance suggests a degree of uniformity in approach.

The way the guidance uses ‘evidence’ implies local intelligence focussing on needs, which is a considerably narrower definition than that understood by most public health professionals. What counts as evidence in public health is contested but a useful delineation of different forms of evidence is proposed by Rychetnik et al. ‘Evidence comprises the interpretation of empirical data derived from formal research or systematic investigations, using any type of science or social science methods’. We distinguish between data on the cause or scale of a health problem (aetiological studies and needs assessment) and evidence on the implementation and outcomes of interventions’ (p. 119). There is also recognition that in a local government context, given the central role of elected members, evidence to support public health action should include the ‘citizen voice’ (p. 20) and incorporate a community perspective.

HWBs offer a substantial opportunity for public health professionals to exert their influence and shape the type of activities that will be implemented within a local authority (LA), with the aim of improving the health and well-being of the population. It is therefore important to assess the extent to which HWSs are able to support and enable this ambition. An initial scoping review of HWSs in one region in England, undertaken by the authors as a pilot for this study, together with national reviews focusing on mental health and diabetes shows HWSs have been written in many different styles and with different content. Informed by this knowledge, a comparative analysis was conducted on a random sample of HWSs available from LAs in England in early 2014 to provide initial insight into these new documents. The research aimed to investigate how LAs have interpreted the statutory guidance for HWBs; the extent to which there is variation in the aims and content of HWSs; how the word ‘evidence’ has been interpreted and used within HWSs and the relationship between HWSs and JSNAs.

Methods

We undertook a qualitative documentary analysis of HWSs using thematic content analysis.

Sampling frame and sampling strategy

The sampling frame was all upper tier LAs in England (n = 152) since they are charged with dispensing public health responsibilities under the Health and Social Care Act 2012. In England local government either provides all local services (known as one tier) or a selection of local services (two tiers). Further details are available from https://www.gov.uk/understand-how-your-council-works/types-of-council. We drew a pragmatic, stratified random sample of one-third of LAs that now have public health responsibilities (see Table 1). Sampling was undertaken in proportion to the percentage of the English population in each region using an online random number generator (www.randomizer.org). As well as being representative of the region and relative population size, the sample also covered the breadth of LA types: unitary (U) (19), county (C) (14), metropolitan borough (MB) (9) and London borough (LB) (8) and hence a balance of urban and rural localities.

<table>
<thead>
<tr>
<th>Region</th>
<th>Population by region</th>
<th>% of English population in region</th>
<th>Number of LAs in region</th>
<th>Number of upper tier LAs sampled from each region</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>2 602 310</td>
<td>4.9</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>North West</td>
<td>7 084 337</td>
<td>13.2</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>5 316 691</td>
<td>9.9</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>East Midlands</td>
<td>4 567 731</td>
<td>8.5</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>West Midlands</td>
<td>5 642 569</td>
<td>10.5</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>East</td>
<td>5 907 348</td>
<td>11.0</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>London</td>
<td>8 308 369</td>
<td>15.5</td>
<td>33</td>
<td>8</td>
</tr>
<tr>
<td>South East</td>
<td>8 724 737</td>
<td>16.3</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>South West</td>
<td>5 339 637</td>
<td>10.0</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>England</td>
<td>53 493 729</td>
<td>100.0</td>
<td>152</td>
<td>50</td>
</tr>
</tbody>
</table>
Data acquisition
Published HWSs were obtained from LAs by searching LA web pages. If we could not identify and download an HWS using this method, an email was sent to the public health department to enquire whether an HWS was available. A non-response was followed up by telephone. To ensure consistency, only published strategies were included and LAs where a strategy was being developed were excluded. All searches and follow-up correspondence were undertaken between October 2013 and January 2014.

Data extraction
The qualitative documentary analysis was conducted from a ‘Realist’ viewpoint which involved establishing an *a priori* set of criteria to investigate, whilst enabling the analysis to be guided by the data that emerged from engaging with the research material. After reading the Department of Health guidance for the production of HWSs and familiarization with a number of strategies from the North East of England as a pilot exercise, a data extraction form was compiled using an *a priori* list of criteria upon which the researchers agreed there may be meaningful points of interest or difference between the HWSs. The criteria aimed to address the three lines of enquiry for the analysis identified by our objectives:

- Scale and scope of HWSs: timescale encompassed by the strategy (measured in years), length of strategy document (measured in pages), use of the following terms: ‘vision’, ‘aim’, ‘objective’ and ‘priority’ or ‘priorities’.
- Prominence and interpretation of evidence within HWSs: use of the word ‘evidence’. References detailing examples of evidence were categorized according to whether they were referring to evidence of need or evidence of effectiveness of interventions, or actions in response to a need. The researchers also screened for references made to local opinion or consultation within the HWS.
- The relationship between HWSs and JSNAs: use of the term ‘Joint Strategic Needs Assessment’ or ‘JSNA’ within HWSs.

In the process of reading the HWSs in detail and extracting data against the *a priori* criteria, additional dimensions of interest became apparent. Additional criteria were subsequently added to the data extraction criteria:

- References made to local opinion/consultation within the HWSs.
- References detailing examples of ‘academic research’ to substantiate claims made within the HWSs in relation to the evidence base.

Each HWS was read in detail by either J.B. or S.S. HWSs were systematically searched electronically and all occurrences of the above terms were located. J.B. and S.S. extracted data from these HWSs into a pre-designed form using Microsoft Word. To ensure the context, and hence meaning was retained, the sentence or paragraph (as appropriate) around each relevant term was extracted verbatim from the document and entered into the data extraction form, with the source HWS and page number of the extract recorded.

Data analysis
Once data extraction was completed, J.B. and S.S. met to review the extracted data and cross-check consistency of data allocation to each of the categories (see Supplementary data, Tables SI–SIII). Interpretation of data was verified by both researchers for Supplementary data, Table SII, where categorizing data required mutual agreement on the intent of the use of the word ‘evidence’ in each occurrence. All authors then reviewed the extracted information to arrive at consensus on lines of similarity and difference between the strategies, and overarching themes emerging from the data. The source of HWSs has been anonymized in presenting the results, but each HWS has been coded according to its authority type (see Table 2 for a key to abbreviations used).

Results
Of the 50 LAs sampled, HWSs were available from 47 and included in the analysis.

Structure and content of HWSs
Strategies varied in timescale spanning 1 (*n* = 7) to 5 years (*n* = 8) (Table 2). Three strategies had no timescales and the most frequent timescale was 3 years (*n* = 17). They also varied in length, from 1 to 92 pages, with an average page length of 25. Most (*n* = 32) strategies had an explicit vision. There was inconsistent use of aims and objectives and some strategies used the terms ‘priorities’ and ‘challenges’, which appeared to be a substitute for objectives. Other terminology used included ‘purpose’, ‘themes’, ‘principles’, ‘outcomes’ and ‘goals’ (Table 2).

The scope of the objectives varied from the high level and strategic, such as:

Objective 7: promoting the health and wellbeing of new populations in [Place Name]. (19.LB, p. 28)

to the more operational and action-orientated:

Increase the number of mothers under the age of 25 who initiate breastfeeding from 17% by 10% year on year for two years. (12.MB., p. 13)

The language used and structures deployed varied in the way in which they were presented, ranging from modestly produced, word-processed documents, with no illustrations or...
### Table 2  Comparison of structure and content of JHWSs—summary data.

<table>
<thead>
<tr>
<th>Strategy reference</th>
<th>Timescale (years)</th>
<th>Strategy length (pages)</th>
<th>Does the strategy have:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>A vision?</td>
</tr>
<tr>
<td>1.LB</td>
<td>2012–15 (3)</td>
<td>28</td>
<td>No</td>
</tr>
<tr>
<td>2.LB</td>
<td>2013–15 (2)</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>3.MB</td>
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<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>4.U</td>
<td>2012–15 (3)</td>
<td>92</td>
<td>No^d</td>
</tr>
<tr>
<td>5.U</td>
<td>2012–16 (4)</td>
<td>16</td>
<td>No</td>
</tr>
<tr>
<td>6.LB</td>
<td>2012–15 (3)</td>
<td>16</td>
<td>No^a</td>
</tr>
<tr>
<td>7.U</td>
<td>Not stated</td>
<td>49</td>
<td>No</td>
</tr>
<tr>
<td>8.C</td>
<td>2013–16 (3)</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>9.MB</td>
<td>2013–18 (5)</td>
<td>36</td>
<td>Yes</td>
</tr>
<tr>
<td>10.LB</td>
<td>2012–13 (1)</td>
<td>16</td>
<td>No</td>
</tr>
<tr>
<td>11.U</td>
<td>2013–15 (2)</td>
<td>32</td>
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</tr>
<tr>
<td>12.MB</td>
<td>Not stated^b</td>
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<tr>
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<td>20</td>
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<td>2013–16 (3)</td>
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<td>Yes</td>
</tr>
<tr>
<td>15.C</td>
<td>2013–16 (3)</td>
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<td>No</td>
</tr>
<tr>
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<td>2013–16 (3)</td>
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</tr>
<tr>
<td>17.C</td>
<td>2013–16 (3)</td>
<td>20</td>
<td>Yes</td>
</tr>
<tr>
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<td>2013–18 (5)</td>
<td>24</td>
<td>Yes</td>
</tr>
<tr>
<td>19.LB</td>
<td>2010/11–2012/13 (2)</td>
<td>40</td>
<td>No</td>
</tr>
<tr>
<td>20.LB</td>
<td>2013–14 (1)</td>
<td>16</td>
<td>No</td>
</tr>
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<td>2013–18 (5)</td>
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<td>24.C</td>
<td>2013–16 (3)</td>
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</tr>
<tr>
<td>25.C</td>
<td>1 year—no start date</td>
<td>24</td>
<td>Yes</td>
</tr>
<tr>
<td>26.MB</td>
<td>2013–16 (3)</td>
<td>34</td>
<td>Yes</td>
</tr>
<tr>
<td>27.MB</td>
<td>2013–15 (2)</td>
<td>8</td>
<td>Yes</td>
</tr>
<tr>
<td>28.U</td>
<td>2013–16 (3)</td>
<td>40</td>
<td>Yes</td>
</tr>
<tr>
<td>29.C</td>
<td>2013–18 (5)</td>
<td>26</td>
<td>No</td>
</tr>
<tr>
<td>30.U</td>
<td>2012–17 (5)</td>
<td>30</td>
<td>No</td>
</tr>
<tr>
<td>31.C</td>
<td>2013–14 (1)</td>
<td>18</td>
<td>No</td>
</tr>
<tr>
<td>32.U</td>
<td>2013–18 (5)</td>
<td>26^c</td>
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</tr>
<tr>
<td>33.C</td>
<td>2013–18 (5)</td>
<td>24</td>
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</tr>
<tr>
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</tr>
<tr>
<td>35.C</td>
<td>2012–16 (4)</td>
<td>27</td>
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</tr>
<tr>
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<td>2012–13 (1)</td>
<td>13</td>
<td>No</td>
</tr>
<tr>
<td>37.U</td>
<td>2012/13–2013/14 (2)</td>
<td>26</td>
<td>Yes</td>
</tr>
<tr>
<td>38.U</td>
<td>2013–18 (5)</td>
<td>16</td>
<td>Yes</td>
</tr>
<tr>
<td>39.MB</td>
<td>2012–15 (3)</td>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>40.MB</td>
<td>2012–15 (3)</td>
<td>10</td>
<td>Yes</td>
</tr>
<tr>
<td>41.U</td>
<td>2013–16 (3)</td>
<td>13</td>
<td>Yes</td>
</tr>
<tr>
<td>42.U</td>
<td>2013–15 (2)</td>
<td>22</td>
<td>Yes</td>
</tr>
<tr>
<td>43.C</td>
<td>2013–15 (2)</td>
<td>17</td>
<td>Yes</td>
</tr>
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<td>44.U</td>
<td>2013–16 (3)</td>
<td>9</td>
<td>Yes</td>
</tr>
<tr>
<td>45.U</td>
<td>2013–16 (3)</td>
<td>24</td>
<td>Yes</td>
</tr>
<tr>
<td>46.MB</td>
<td>2013–16 (3)</td>
<td>16</td>
<td>No</td>
</tr>
</tbody>
</table>

Continued
pictures, to documents illustrated in full colour that appeared to be professionally designed.

**Use of ‘evidence’ in HWSs**

Thirty-eight strategies used the word ‘evidence’ in a diverse range of ways (Supplementary data, Table SII).

Most often, evidence was used to mean ‘evidence of need’. This was usually identified through the JSNA and appeared to be locally gathered intelligence rather than from a national source of research evidence or intelligence. Examples of evidence referred to in this way include:

> We’ve been working on our Joint Strategic Needs Assessment (JSNA) to analyse the health needs of the population to build up an evidence base of the health and social care priorities for adults and children in the borough. (10.LB., p. 6)

The JSNA, and the data which informs it, provides the key evidence-base for health, public health and social care commissioning across the local area. (7.U., p. 3)

The most referred to national source of evidence of need was the Marmot Report\textsuperscript{16} which was cited as justification for proposals in 19 of the strategies:

> The Marmot Review of Health Inequalities ‘Fair Society, Healthy Lives’ provides evidence that there is a bigger impact on the health for those living in deprivation. (27.MB., p. 3)

The evidence from the Marmot Review and the concept of the health gradient as show in the diagram above, makes clear that the greatest opportunities to reduce health inequalities, are during childhood where focused preventative activities really can make a lifetime difference. (1.I.B., p. 10)

There were few instances of evidence cited to mean effectiveness of interventions and these often did not give specific sources:

On a positive note, there is good research evidence of interventions which work and are cost-effective, ranging from preventative measures such as minimum alcohol pricing for alcohol, through brief interventions for hazardous drinkers, to psycho-social treatment for dependent drinkers. (4.U., p. 82)

Our approach is to concentrate on a limited number of strategic interventions which . . . . Are underpinned by good national and/or international evidence of effective interventions. (28.U., p. 9)

There were five HWSs that cited academic journals. This was in the context of evidence of need, not effectiveness. There were three references to NICE guidance (1.I.B., p. 14; 4.U. p. 20, 91; 21.U. p. 11) and none to Cochrane Reviews. Most frequently, sources were not acknowledged, making it hard to judge the rigour or authority of statements like the following:

> Based on evidence work has been undertaken in [Place Name] to improve transition between schools, particularly in rural areas and for alcohol misuse services and domestic and sexual violence and abuse services, there is a need to make further improvements particularly for children leaving care. (15.C., p. 16)

Whilst the benefits of having a really rigorous and objective prioritisation process are clear, it is important that the local HWB is also able to focus on local wellbeing issues that do not necessarily form part of the JHWS. These may be emerging issues, where we do not yet have definitive evidence but where we know there is a major impact. (7.U., p. 6)

Overall, only one-third of strategies referenced evidence of both need and effectiveness. Of the remainder twice as many

\begin{table}
\centering
\begin{tabular}{|l|c|c|c|c|}
\hline
\textbf{Strategy reference} & \textbf{Timescale (years)} & \textbf{Strategy length (pages)} & \textbf{Does the strategy have:} & \\
\hline
& & & \textbf{A vision?} & \textbf{Aim(s)?} & \textbf{Objective(s)?} & \textbf{Priorit(ies)?} \\
\hline
47.U & 2013–14 (1) & 12 & Yes & Yes & No & Yes \\
\hline
\end{tabular}
\end{table}

\textsuperscript{a}MB, Metropolitan Borough, LB, London Borough, U, Unitary, C, County.
\textsuperscript{b}Published December 2012.
\textsuperscript{c}Pages misnumbered, no page 2.
\textsuperscript{d}Refers to council’s overarching vision.
\textsuperscript{e}States that of the Health and Wellbeing Board, not the HWS.
mentioned evidence of need only compared with evidence of effectiveness only \((n = 7)\). Statements resulting from community engagement and local opinion were included alongside other sources of evidence:

Listening and responding – People living in [Place Name] know best about the greatest problems and challenges to their health and wellbeing. We will listen closely to learn what really matters and how we could make a difference by developing the way we engage and communicate with residents. (38.U., p. 7)

Work done to agree these priorities drew upon evidence from the [Place Name] Joint Strategic Needs Assessment (JSNA) and following engagement with local communities, organisations and other groups who work in the area of health and wellbeing. (45.U., p. 7)

The challenge of defining evidence and how it is used in the context of LAs is illustrated in the following extract from one HWS:

We are clear that decisions have to be based on evidence. This is a simple principle but we also recognise that there are challenges: evidence from different sources presents convincing pictures; quantitative and qualitative evidence about the same circumstances may not easily be amalgamated to present a comprehensive picture; and board members bring different types of expertise and may have different views about relevant evidence methodologies. (37.U., p. 20, 21)

### Link between HWSs and JSNAs

Most HWSs referred to JSNAs (Supplementary data, Table SIII) with some strategies acknowledging the statutory guidance and making explicit links between their JSNA and HWS:

The strategy is based on the city’s Joint Strategic Needs Assessment (JSNA) and feedback from local organisations, patients and the public. (28.U., p. 6)

The [Place Name] HWB has developed a Joint Strategy; this is a statement of the Board’s vision, priorities and goals based on the findings of the [Place Name] JSNA 2012. The JSNA was consulted on widely; this included a well represented Stakeholder event during 2012. (41.U., p. 3)

There were two strategies that did not make any reference to their JSNAs.

### Discussion

#### Main findings of this study

Our findings suggest that LAs have varying interpretations of what should be in an HWS. Most timescales were short, 3 years or less. ‘Evidence’ was infrequently used to mean evidence of effectiveness or cost-effectiveness derived from rigorously conducted research studies or systematic reviews. Neither the guidance nor any of the HWSs gave a definition of what constitutes evidence. Although most HWBs stated they had used their JSNAs to inform their strategies, not all stated they had done so, despite a clear requirement in the statutory guidance.

#### What is already known on this topic

Marmot\(^\text{16,17}\) suggested that ‘Scientific findings do not fall on blank minds that get made up as a result. Science engages with busy minds that have strong views about how things are and ought to be’. As with governments generally, this could be the situation in LAs, with public health professionals promoting actions that do not fit with LA elected members’ or officers’ or the public’s views and opinions. Debate about which public health interventions should be implemented may be appropriate when there is no definitive research evidence. However, where robust research evidence exists it should be used. A review of 100 HWSs,\(^\text{11}\) investigating the inclusion of mental health issues, found a range of both positive and negative aspects. However, its conclusions reflect our findings that HWSs content is variable in terms of the ambition and strength of the rationale for proposed actions. A review of 24 HWSs in relation to diabetes\(^\text{12}\) also found variation in content.

A recent national survey\(^\text{18}\) found that, even within the field of public health, there is a difference in how people define ‘evidence’. The evidence most frequently used by respondents comprised systematic reviews, peer reviewed journals and analysed data. These were not the sources of evidence referred to in the majority of HWSs we analysed.

#### What this study adds

To our knowledge this is the first study to review a representative sample of HWSs in relation to the statutory guidance, to assess the way in which they have used ‘evidence’ and to identify the extent to which JSNAs have informed their development.

LAs have varying interpretations of what should be included in an HWS, the timescale of strategies, their length and depth. Our findings indicate a spectrum of ambition that LAs have for these strategies. This study contributes to the debate about what types and forms of evidence should be used to support LAs’ public health strategies. Despite the
importance of needing to know if proposed interventions are effective, the first wave of HWSs suggests they predominantly used evidence of need rather than evidence of effectiveness to underpin priorities. Most strategies followed the statutory guidance for developing HWSs. However, this too focuses on evidence of need rather than evidence of effectiveness. Our findings suggest that stronger, clearer guidance is required.

Limitations of this study

Each HWS was only read in full by one researcher and although queries were discussed between researchers, it is possible that some differences in interpretation were not uncovered and resolved. Although the sample was random and stratified, it represented only a third of HWSs and may by chance have failed to represent the full range of content of HWSs.

Documentary analysis has proved an insightful method for making comparisons across areas in how a mandatory, publicly available publication has varied. However, a major limitation to this approach is that the analysis cannot take account of the context in which the HWSs were developed and how they are being used. Whilst our research has uncovered variations in approach to HWSs, it does not explain why these have occurred or indeed what the impact of these variations might be. Further mixed-methods research is required to explore the interrelationship between the HWS, the work of the HWB and the organization and delivery of public health at a local level more generally.

Interpretation, conclusions and implications

The diverse structure and content of the HWSs reviewed in this study is of concern since this is unlikely simply to reflect variation in characteristics of LAs, but more fundamental differences of approach in how best to achieve the ambitions set for HWBs. Inconsistency of language and approach may be unimportant if the overall structure provides a clear sense of what is to be achieved and how it will be accomplished. However, inconsistency may be confusing for those partners working with more than one LA, such as clinical commissioning groups (CCGs) and NHS hospital trusts. The short timescales apparent in many HWSs suggest the scope of change that HWSs are realistically expecting to achieve may be limited. Longer timescales with SMART objectives would indicate a scale of ambition that could better address major public health challenges. The different document lengths reinforce the variable understanding among LAs of how HWSs should communicate their vision and objectives or priorities. To be useful they need to balance brevity and accessibility with sufficient detail to demonstrate how they intend to address needs identified in the JSNA and the rationale for the actions to meet those needs. Although most HWBs used their JSNAs to inform their strategy, not all did, despite a clear requirement stated in the statutory guidance. The success of the HWB will depend to some extent on the use of, and interrelationship between, these documents.

There is an inconsistency between the rhetoric of using the word ‘evidence’ in HWSs but not identifying the sources of evidence. This inconsistency is not new and may be endemic in the English health system. In 2011, Katikireddi et al. demonstrated that the government’s white paper, Healthy Lives, Health People, proposed a substantial number of interventions that were not justified by evidence of effectiveness. This approach to using the word evidence without recourse to a robust evidence base has been described as the ‘primacy of political priorities’ (p. 486) where although evidence is championed by governments, policies are enacted to support political imperatives rather than in accordance with research evidence. A systematic review has identified the complex range of political factors that have shaped the uptake of public health policies internationally.

Whilst the new public health system is still evolving, the opportunity exists to develop clearer guidance about the production and purpose of HWSs. There also needs to be a shared understanding of what constitutes ‘evidence’ and how it can be generated and used to influence HWSs.

If HWSs are to provide sound frameworks for CCG and LA commissioning plans to prioritize the use of scarce resources, then a greater use of evidence of cost-effective interventions is required. This is not a new concern. In 2004, the Wanless Report highlighted the need for public health evidence about effectiveness and cost-effectiveness to inform policy. Our analysis suggests a strong link between academic public health and the practice of public health in LAs in England may currently be absent. Our finding that research evidence about effectiveness was not widely used in the HWSs is consistent with the Royal Society for Public Health’s 2013 survey, which reported that over half of their respondents believed that LA health decision-making was based more on political processes than on evidence. Similarly a review of the use of research evidence in public health decision-making found a range of influences on decisions about public health policy which led the authors to suggest that greater communication was required between researchers and decision-makers. Both this and a non-health study identified political influences in the use of evidence in policy decision-making. Our study suggests that, while not discounting the importance and place of political processes, public health evidence ought to contribute significantly more prominently to decisions about
effectiveness. South et al.9 and others26 have proposed that a broad range of types of evidence, including case studies and local consultations, as well as systematic reviews, should be used to inform LA public health decisions.

An initiative from Public Health England and the Academy of Medical Sciences27 to develop the relationship between public health research and its implementation is welcomed as a way of addressing some of the concerns raised by this study’s findings. Local academics and LAs could also explore ways in which they could develop a research evidence base for topics specific to their populations. AskFuse (a responsive research and evaluation facility provided by Fuse, UKCRC Centre for Translation Research in Public Health)28 and the National Institute for Health Research School for Public Health Research’s Public Health Practitioner Evaluation Scheme (a responsive research funding scheme with similar aims, recently launched nationally)29 are tangible examples of how this could be implemented, but there may be other viable models. Qualitative research exploring the views of LA elected members and officers, including public health specialists, may help to shed light on how to strengthen HWSs as they address significant challenges to improving health and wellbeing. In addition, future research drawing on the knowledge translation and research transfer literature could help LAs determine future HWS content.

Supplementary data

Supplementary data are available at the Journal of Public Health online.

Authors’ contribution

J.B. had the idea for the study. J.B., S.S. and M.W. designed the study and developed the methods, with input from D.J.H. Data collection, verification and analysis were carried out by J.B. and S.S. J.B., S.S., D.J.H. and M.W. interpreted the data. J.B. wrote the first draft of the paper. J.B., S.S., M.W. and D.J.H. contributed to subsequent drafts of the paper and approved the final draft.

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References

14 Office for National Statistics. Population estimates for UK, England and Wales, Scotland and Northern Ireland, Mid-2011 and Mid-2012,
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