Local Government Association

An effective custodian of the public's health

A collection of essays on six years of public health in local government

About this publication

Public health made the formal transfer to local government in April 2013, and in the last six years great strides have been made to tackle the wider social and economic determinants of poor health.

This publication was commissioned by the Local Government Association (LGA) to capture the thoughts of those working hard to make the new system work with contributions from councillors, directors of public health, providers, commissioners, academics and other key decision makers.

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Disclaimer

The views expressed in the publication are those of the contributing authors and do not necessarily reflect the views of the LGA.

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Foreword

After almost six years, I hugely admire the way council leaders, cabinet members, chief executives, directors of public health and their teams remain full of commitment and inventiveness, despite the financial barriers they face.

Good public health, by drawing imaginatively on all of local government's functions, can make a real, large-scale difference on all levels. From promoting the independence of people with long-term chronic conditions, to actually preventing ill health, good public health services can help to reduce pressures on social care and the NHS, and tackle health inequalities all whilst maintaining its primary goal of improving people's lives and wellbeing.

Innovative practice from individual councils shows just what potential there is for public health, if properly resourced, to make inroads into improving health and wellbeing, and to do it efficiently. We have, on a number of areas, delivered better outcomes at less cost than the NHS did when they controlled public health.

Public health teams, working with a 'health in all policies' approach across councils, are tackling persistent problems like adult and childhood obesity, mental illness, alcohol and drug misuse, sexually transmitted infections and the health impact of isolation and loneliness in old age, as well as addressing some of the serious health inequalities that still exist within and between communities.

There is no silver bullet for England's main public health challenges, the immediate causes of which remain tobacco use, poor diet, physical inactivity and alcohol misuse. Each is driven by a complex web of socioeconomic circumstances that the NHS alone cannot address. Teenage conception rates have plummeted and youth smoking and drinking rates are lower than they've been for decades. The challenge now is to break the generational cycle of disadvantage that drives health inequalities. There is growing evidence that intervening in the first 1,000 days of a child's life can make a difference over their whole lifetime.

The rationale for a local government lead is unchanged: that the greatest impacts on health are in the circumstances in which we live, employment, education, environment and the effects of the social gradient of health, that is, equality or the lack of it. Local government, while often limited itself in its influence, can certainly impact more on these factors than the NHS.

Local government has the legitimacy and the record of efficiency gains and commissioning experience to provide leadership in this process. More local, joined up and innovative ways of working are also inherently linked to the need for better fiscal discipline, and this is likely to continue. The way that we use our money cannot be constrained by history and what has been done before. Nor can we afford to experiment. We need to be led by experience and evidence of what works.

Of course, there remains an important role for national policy making but this cannot be a substitute for local leadership and local responsibility for improving the health of local people. It is right that those decisions are being made where the action happens.

Councillor Ian Hudspeth
Chairman, LGA Community Wellbeing Board

Councils as the home for public health: an idea whose time has come?

Jo Bibby
Director of Health, Health Foundation

The move of public health teams in England to councils in April 2013 might have been summarised as 'a good idea, bad timing'. A good idea, because as a function whose responsibility is to create and maintain health it was going to have more influence on the wider determinants of health within local government than within the NHS. Bad timing, because in 2013, councils were at the start of a period of funding cuts which would see their budgets fall by over 30 per cent between 2010 and 2018.[1] As a result, the priority for many public health teams after the transition was damage limitation rather than seizing new opportunities.

At the time, many described the move as 'public health coming home', reflecting the origins of modern public health in the social reforms of Victorian Britain. And while some of the challenges may have changed, many of the factors shaping people's health today certainly echo those of the past – poor housing conditions, poor air quality and poor diet. Thus, the opportunities for public health professionals to work across local government and embed a health in all policies approach were replete.[2] Without a doubt, in many places this opportunity is being seized to great effect, taking the opportunity to influence housing, planning, transportation and the design integrated health and social care systems.

Yet, in a context of ever deepening cuts, there is only so far that innovations can help with achieving the same with less, and opportunities to influence become severely restricted. The debate being more often one of where cuts can do the least harm than where investment can deliver the greatest benefit.

But, perhaps, there is now room for cautious optimism? Over the past few months there feels to be a new narrative emerging. The consequences of the cuts are being called out with more frequency. Most starkly by the UN's special rapporteur report on extreme poverty who observed that 'local authorities, especially in England, which perform vital roles in providing a real social safety net have been gutted by a series of government policies'.[3] There is also a crack appearing in the political discourse. Both Theresa May and Philip Hammond have spoken of austerity coming to an end and Matt Hancock has acknowledged that the cuts in the public health grant need to be looked at in the forthcoming spending review.

So, what if the tide is beginning to turn? What if directors of public health are going to find that they are finally working in an environment where there is some possibility of investment?

If this scenario emerges over the next few years the question is going to be where to focus. It will be hard to know where best to start – and each place will have its different priorities. But a shared challenge will be balancing the demands of the here and now with the need to invest in the future.

1 www.nao.org.uk/report/financial-sustainability-of-local-authorities-2018
2 www.local.gov.uk/health-all-policies-manual-local-government
3 www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23881&LangID=E

In this context, leadership from public health will be critical and the opportunities presented by its position in councils can finally come to the fore. Public health that can ensure decision makers take the long view and think about the communities they want to be leading in 10, 20 or even 30 years' time. That they think about the benefits that can be reaped from making investments today in the conditions and services that keep people healthy.

The Health Foundation's briefing paper, 'Our nation's health as an asset' sets out the need for people's health needs to be viewed differently – not the output of a prosperous economy but an essential input to a flourishing society.[4] People's health needs to be viewed as something to be invested in over the long term through creating healthy places, providing the support needed for early years development and ensuring that everyone has the opportunity to access good quality work and workplaces. In short health needs to be seen as integral to the prosperity of a place as features such as transport, utilities and digital infrastructure. Every part of local government needs to feel the greatest responsibility and accountability for the health of their residents.

The transition of public health into local government happened at a difficult time but, to paraphrase a Nobel laureate, perhaps the times are a changin'.

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> "Every part of local government needs to feel the greatest responsibility and accountability for the health of their residents."

4 www.health.org.uk/sites/default/files/upload/publications/2018/The%20nation%27s%20health%20as%20an%20asset.pdf

The six years of a long journey

Greg Fell
Director of Public Health, Sheffield City Council

Six years in to a long journey gives an opportunity to reflect on successes and lessons learned. Most in local government are looking forward to the next phase of development of the public health responsibilities of local government. Looking back a lot has changed over the last few years. Looking forward there is a lot more change to come.

The basic responsibilities of the public health function broadly remain unaltered. To protect the public's health, to ensure the right set of strategy and programmes is in place to promote health and wellbeing.

There is still a need to ensure that vaccination rates are high, that there is capacity and capability to respond to outbreaks of infectious disease. There is still a need to ensure local authorities commission high quality 0-19 services, or drug and alcohol services. These, and other services funded through the public health grant, ensure high coverage of high impact high value preventive interventions. These basic responsibilities are largely unaltered.

We all know 80 per cent or so of what determines health is out with the NHS, it's not going to get influenced from outside. Local government is responsible for a vast array of services,[5] has thousands of responsibilities and duties,[6] almost all of which are 'public health' in some way, shape or form.

The job of public health in local government is to improve health, not to commission or provide some services paid for by a bag of cash called the public health grant. Thus the statutory duty is to improve the health of the population, not to provide some public health services.

Being 'in' the organisation that's responsible for many of the things that determine health in places we live matters. Being 'in' local democratic organisations matter, and matters a lot.

Over the last five years the responsibility for public health in local government has become significantly strengthened. The sense of long term investing in places and the health and wellbeing in places has become strengthened compared to previous eras.

The place has always mattered. The public bit of 'public health' has always mattered. What has changed over the past five years is the meaning of the term 'public health' and how it is contextualised in our places.

The responsibility for the services funded by the grant continues, these services don't have to be funded by a ring fenced block of resource. A future move to funding through business rate retention will further strengthen the sense of place based investing, and the notion that those services are a fundamental part of that investment.

One of the more interesting changes has been the changing nature of what people consider to be 'public health', moving from a set of defined services towards a responsibility to improve the health of a population.

5 https://protect-eu.mimecast.com/s/3r2dCvgJLcQrZMcQ6xUs
6 https://protect-eu.mimecast.com/s/mNq_Cwjg7IBgnYsq1--I

The organisational landscape around which public health functions operate remains complex. This is the case across health services, health protection and health improvement. Ultimately local authorities will be held accountable for improvement in health or where there are problems around health protection; they are responsible for pulling together a coherent response across many agencies, many of which are not within the gift or direct control of local authorities. This underscores the importance of authoritative leadership.

We have continued to ensure the core responsibilities of the director of public health are discharged, and that the services expected from the public health grant are delivered. Grant cuts have forced changes however. Where we have made changes we have ensured the changes reflect a broad policy of pushing upstream in our approach to prevention.

In Sheffield some of the bigger changes we have made have meant we have pushed our investments further upstream. For example in tobacco and obesity we have taken a view around framing these as commercial determinants of health rather than lifestyle choices. Thus we have invested heavily in tobacco control initiatives such as enforcement against illicit tobacco, schools based prevention interventions and initiatives to change the food environment and attitudes to sugar. In childrens mental health we have changed the nature of our investment profile and invested in whole school approaches to emotional health and wellbeing, as opposed to purely investing in treatment services. The early indications are that this is beginning to reduce demand for more intense treatment services.

We have established excellent links between public health, safeguarding teams and the licencing authority, and are implementing interventions using licencing powers around the alcohol environment and gambling.

We have invested in revitalising parks and green spaces, as part of a broader strategy, so that we can protect and promote our green spaces, especially focused on the most disadvantaged areas. Using inclusive growth as a catalyst we are linking together our approach to economic policy and health and wellbeing, especially seeking to capitalise on economic anchors at city and neighbourhood level.

In these and many other areas, we are strategically using the public health grant to push the cities approach to health and wellbeing into the mainstream, and setting up the ask that all services and functions within the city seek to improve health and wellbeing. For the city this is the responsibility of the health and wellbeing board

It hasn't always been plain sailing. The transfer of responsibility in the context of ongoing austerity has made for many difficult decisions. This has forced a great deal of change. We all knowcuts to the public health grant are a false economy, and in effect means cuts to the NHS. The asset stripping of local government is a public health disaster. The services funded by the ring fenced budget are small beer in the bigger context.

We all know that ongoing cuts to local government funding will have a significant impact on health and wellbeing both now and well into the future. The Alston report[7] on extreme poverty provides ample evidence of this.

Despite all the budget doom, the future remains positive. Public health in local government was never a drag and drop exercise, change was always going to happen.

We can't commission our way out of many problems solely by focusing on the services within the grant. We need to move upstream, if nothing else, THAT was the point of the transfer.

7 www.ohchr.org/Documents/Issues/Poverty/EOM_GB_16Nov2018.pdf

Our observation is that most of those who call for public health to be returned to the NHS haven't worked in town hall public health. In my experience most of those telling me the transfer to local government was a disaster don't actually know the history of public health, don't understand its breadth, depth and scope, don't understand the role of society and systems, or that modern medicine is only possible if you have resilient civic functions like housing, education, environmental services and social care.

There is a quiet revolution going on as we push our approach to public health further into the core decision making processes for the city and place based investment, and away from a narrowly defined concept that was related to health care.

"In Sheffield some of the bigger changes we have made have meant we have pushed our investments further upstream."

"We can't commission our way out of many problems solely by focusing on the services within the grant. We need to move upstream, if nothing else, THAT was the point of the transfer."

Local authorities: the linchpin between communities and the NHS

Stacey Arnold
Local Public Affairs and Campaigning Manager, Cancer Research UK

Since 2013, many local authorities have embraced their role as system leaders for public health and their ability to deliver isn't in doubt. But the separation of the NHS and local authorities has, at times, been unhelpful. While the additional £20.5 billion for the NHS is welcome, it masks the fact that cuts to public health funding have hampered efforts to meet local health needs. Ironically the consequence of this is often greater reliance and demand on the NHS. Sustainable public health funding would relieve many of these pressures.

We hope the declared end to austerity, the NHS 10-year plan and the prevention green paper will mark a significant change for public health – in investment and attention. Councils are essential if we are to invest in targeted prevention closer to home, and if we are to realise true health and social care integration. One example is the Ottawa model[8], which offers stop smoking advice and nicotine replacement to smokers when they are admitted to hospital. Evidence shows this works. So, it makes sense to back this up with community services if we want those smokers to stay tobacco free beyond discharge.

At Cancer Research UK we have an ambition to create a smoke-free UK by 2035, where less than five per cent of adults smoke. As the biggest preventable cause of cancer and premature death in the UK, the impact of smoking on health can't be overstated.

8 https://ottawamodel.ottawaheart.ca/

Smoking must continue to be addressed and local authorities have an important role to play in this.

We've seen some great tobacco control activity happening across the country. A notable example is the significant drop in smoking rates in the north east, led by the regional tobacco control programme, Fresh. Also, the 'Making Smoking History' programme combines tobacco control interventions across Greater Manchester, with activity delivered by 10 individual boroughs. From Thurrock to Wigan, Hertfordshire to Hull, a consistent theme is collaboration – whether that's with the NHS, the voluntary and community sector, social housing or other council departments.

But still, a recent Health Foundation report showed that spending on tobacco control has dropped by 32 per cent since 2014 – the biggest drop in all areas of public health provision. We know political support for tobacco control remains high yet, in 2017, 50 per cent of councils reduced budgets for smoking cessation – with reduced funds cited as the main reason. This is the falsest of economies.

It's concerning that the drop in funding has created a 'gap' that the tobacco industry has sought to fill with questionable commitments to be 'part of the solution' while heavily plugging their own products. The industry must have no role in public policy-making.

Looking ahead is tricky given the scale of political and economic uncertainty. Devolution has profoundly changed local government – encouraging greater local responsibility and creating a new tier of government through metro mayors.

Health devolution in Greater Manchester has created opportunities for integration and reform, with an ambitious smoking plan just one of the positive examples. Early indications are good, but the ultimate outcomes remain to be seen. The appetite for devolution remains strong locally, but there appears to be a mood of 'devo-indifference'. While Brexit continues to dominate the Westminster agenda, we predict no major change in form.

What we do know for the future gives cause for concern. From April 2020 public health is to be funded through 75 per cent business rates retention (BRR). How this will work is unclear. Public health was excluded from the fair funding review and the BRR model has only been piloted in Greater Manchester (which is anomalous in many ways). As well as understanding the size of the funding envelope, clarity is needed on the method of funding redistribution. Government must ensure that weaker local economies with greater health needs aren't worse off as a result of this change – for fear of exacerbating health inequalities. What we've yet to see is a robustly tested and evaluated scheme that we know is fit-for-purpose. We continue to call for clarity.

We know that opportunities for local authorities to improve health inequalities is vast, through a health-in-all-policies approach and a focus on the wider social determinants. Local authorities are vital for closing the health inequalities gap. Research shows the impact the environment can have on the choices individuals make – from exposure to advertising, to the number of local takeaway outlets. And there is a clear correlation between poverty and these preventable risk factors. For example, smoking is responsible for half the difference in life expectancy between the rich and poor, and 27 per cent of households in England with an adult smoker are below the poverty line. Through licensing, housing, trading standards and all manner of other council functions there is fertile ground for health improvement.

And while putting a focus on influencing the wider determinants is sound, there are immediate health gains to be made by supporting people to improve their health now through local health services. And yet key services continue to fall victim to cuts to public health. Evidence for the effectiveness of stop smoking services is robust: they save lives, save money, reduce inequality and support a sustainable health and social care system. According to NICE, every £1 spent on smoking cessation saves £10 in future health costs yet they continue to be cut.

There is great potential within local government that can be realised if the right political and economic conditions support it. Services work, and while they're only part of the wider public health portfolio, they still have a tangible impact on outcomes and inequalities. We hope sustainable funding will enable a better balance between interventions that influence the wider social determinants and the immediate health outcomes of services.

"There is great potential within local government that can be realised if the right political and economic conditions support it. Services work, and while they're only part of the wider public health portfolio, they still have a tangible impact on outcomes and inequalities."

Choices that are made today will impact for generations to come

Professor Eugene Milne
Director of Public Health, Newcastle City Council

In 2014, researchers in Utah reported that the US public believed 80 per cent of the increase in life expectancy between 1850 and 2011 was a consequence of health care, whereas any reasonable estimate of actual impacts would place it well below 20 per cent.[9] Nye Bevan, famously, hoped the cost of the NHS would fall as the health of people improved through the assumed consequences of its success.[10]

These assumptions of health care efficacy and its capacity for (take your pick of) reduced need, demand or cost, are persistent and too frequently unquestioned. One can trace them as articles of faith all the way to the new NHS Plan which, despite mental ill-health and learning disabilities gaining some well-merited prominence, still emphasises causes of death, individual behaviour and 'responsibility' – three cardinal errors that threaten to entrench rather than resolve the great challenge of achieving long and healthy lives, and with respect to which action frequently worsens rather than reduces inequalities.

Public Health England has recently promoted some excellent visualisations of the 'Global Burden of Disease Study' that deserve examination on this score.[11]

9 Lindsay GB, Merrill RM, Hedin RJ. The Contribution of Public Health and Improved Social Conditions to Increased Life Expectancy: An Analysis of Public Awareness. J Community Med Health Educ 2014; 04. doi:10.4172/2161-0711.100031

10 The National Archives. Management in the 1950s. Cabinet Pap. www.nationalarchives.gov.uk/cabinetpapers/alevelstudies/management-1950.htm (accessed 2 Dec2018)

11 The Institute for Health Metrics and Evaluation (IHME). GBD Compare | IHME Viz Hub. 2018. https://vizhub.healthdata.org/gbd-compare/ (accessed 2 Dec2018)

Taking a British population and examining burden as illustrated by deaths in comparison to the burden of years lived with disability is enlightening. The huge mortality dominance of cardiovascular disease and cancers shrinks to a tiny fraction of the years lost to musculoskeletal disorders, mental ill-health and sensory impairments.

Crucially, the latter are those factors that prevent work, participation, leisure activities, and social interaction. They are fundamental to the possibility of being and remaining as healthy and happy – and as equitably – as possible. Their amelioration creates the potential for subsequent avoidance of those pathways that lead to death from cardiovascular disease or cancer.

The route from a state of good health to the NHS plan priority diseases is not commonly one of choice and individual behaviour – those are factors, but they are at the mercy of circumstances. It is lazy thinking to blame social gradients of obesity or smoking on choice or lack of moral fibre among the poor and disadvantaged. Behaviours matter, but behaviours are shaped by environments, environments are shaped by societal choices and a key channel for those choices is local government.

Just as broader influences on smoking such as legislation, campaigns, and regulation have been an order of magnitude greater in their impact than have smoking cessation services, so too will be the environmental influences upon physical activity, social connectivity and healthy work when compared with healthcare-based secondary prevention for those with established conditions.

Ultimately, I suggest, we will achieve more in improving and maintaining health through transport infrastructure, parks, planning and regulation than can possibly be achieved by better recognition of those already suffering the consequences of failure to act on those factors.

And what is being missed in NHS bickering about reduced funding for public health 'services' – as if that had been a choice in the face of budgets slashed with barely a squeak of complaint from clinicians – is the engagement of public health thinking in, for example: transport policy and response to Defra's requirements for NO2 reduction; in action through planning to regulate alcohol and fast food outlets; in developing synergic support through libraries; in working with businesses to develop healthier workplaces; in collaborating to build industrial strategy that places wellbeing and health at its centre to deliver genuinely inclusive growth; in engaging with communities to argue the difficult choices needed in prioritising health over individual or economic convenience.

By its very nature, public health is slow in manifesting change. But that change has an inexorable momentum and a lasting legacy of benefit.

June 28, 2012 in Newcastle is popularly known locally as 'Thunder Thursday' – the day when a storm of truly spectacular proportions broke over Tyneside. Take a look at the YouTube video of a manhole exploding like a geyser for an idea of the conditions (www.youtube.com/watch?v=HVHM5VXg2tk), and consider that in 1854, the Town Surveyor, Robert Wallace, had concluded that certain of the sewers under construction were "too big for the steep declivity of the town", and on two occasions he had seen sewers explode as "when large quantities of storm water rushed down and hit the river… like a battering ram, thus causing the sewers to burst".[12]

12 Friswell CA. Did king dirt and bumbledom defeat the objects of the public health act, 1848?: A case study of the political, social and cultural attitudes to public health reform in Newcastle-upon-Tyne, Gateshead and Sunderland,1835-1858. Available at Durham E-Theses. 1998

The choices made by Victorians still impact upon our cities in ways that we do not register. And the choices that are made in shaping the environments today will impact for generations to come.

The grumbles of the NHS about choices in health improvement and changes to public health 'services' are short-sighted and ill-informed. Public health requires a longer and more rational view, and its proper home is in local government.

> "It is lazy thinking to blame social gradients of obesity or smoking on choice or lack of moral fibre among the poor and disadvantaged. Behaviours matter, but behaviours are shaped by environments, environments are shaped by societal choices and a key channel for those choices is local government."

Reminding the health system of a worldview which local government has always held is vital

Mike Sandys
Director of Public Health, Leicestershire County Council

The recent Department of Health and Social Care (DHSC) policy paper: 'Prevention is better than cure: our vision to help you live well for longer' is, of course, to be welcomed. However, I am not sure many people would recognise its relevance to their influences on their own lives and their health.

For adults living with debt, addiction, housing or employment problems, the ability to make healthy choices without support will be an aspiration for others, not for them. Most people would recognise that the social determinants of health are the key issues in enabling people to 'take control', to use a popular phrase, of their own long term health.

In the run up to the Health and Social Care Act 2012 the Government articulated what they wanted from local authority public health in a series of 'factsheets'. The vision expressed for local government leadership of public health was for local authorities, amongst other things, to be:

- [championing] health in all policies so that each decision seeks the most health benefit for the investment, asking key questions such as "what will this do for the health and wellbeing of the population?"
- supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people)
- tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs, rather than commissioning a plethora of single issue services, and using new technologies to develop services that are easier and more convenient for users.

In Leicestershire, the council has made progress in achieving those aims, even in the most strained of financial times. Locally the council has developed a social model of public health that offers a service to address the social determinants, alongside work with policy makers across the county council and districts to seek longer term improvement on health. This has led to the involvement of public health in a number of services with a strong emphasis on community capacity as the basis for prevention.

At the community level, public health has invested in a team of local area coordinators and a time banking scheme to support the empowerment of individuals and communities. Service delivery includes a welfare and social support service and a programme of work by a public health programme delivery team, working in a 'settings based' approach including schools, employers and pharmacies. Lifestyle services are increasingly delivered by mainly digital means, offering a more flexible service to the community.

At a broader level, a 'health in all policies' (HIAP) approach has led to significant benefits. The public health team have undertaken Health Impact Assessments (HIA) on a number of local plans across Leicestershire and have contributed to larger HIA work on HS2 (high speed two railway).

Additionally joint work with planners has seen a strategic approach to enabling physical activity in the county. The work has facilitated developers and council planning teams to design enhanced physical activity opportunities into new housing developments.

Taking a HIAP approach, the public health team has piloted working closely with the planning department at Hinckley and Bosworth Borough Council on an 'Active By Design' programme based on the 10 Principles of Active Design developed by Sport England. A checklist has been developed to help planners assess whether new planning applications have taken account of the 10 active design principles.

As always, much has been achieved, but more could be done. Resource remains an issue. With a reducing public health grant the 'space' to develop the social model has been limited. Health partners are beginning to appreciate the worth of what that social model can bring to integrated locality teams and the 'social prescribing' offer of the NHS, but without funding the ability to develop the model further will be constrained.

National policy direction and powers to underpin that direction would help too. The HIAP examples set out here have been achieved by working with a 'coalition of the willing' across district council partners. Inevitably, not all HIAP recommendations can be delivered but moving from a' nice to have' to a 'must consider' basis would give some limited teeth to policy work.

Lastly, reminding the health system of a worldview which local government has always held is vital. One where service configuration and demand management initiatives are rooted in an understanding that dealing with the realities of people's lives , drawing on the wider range of services and community assets in their area, is essential.

"For adults living with debt, addiction, housing or employment problems, the ability to make healthy choices without support will be an aspiration for others, not for them."

"Most people would recognise that the social determinants of health are the key issues in enabling people to 'take control', to use a popular phrase, of their own long term health."

Being innovative is key

Councillor Sue Woolley
Chairman Lincolnshire Health and Wellbeing Board, Lincolnshire County Council

Local government has always had a role in addressing how the world makes it easier, or harder, for us to be healthy and well. It looks at what we call the wider social determinants of health, and thus is a natural fit for public health teams.

We in local government focus on the local context to ensure we are best placed to address and change things that make it difficult for people to live the lives they want.

Lincolnshire is a great example of working in this way to improve public health; a large, rural county working hard and innovatively to overcome the barriers to health that come along with the beautiful green fields and open skies.

Lincolnshire has a population of around 750,000 people – only the 16th highest county population in England, but the fifth highest number of people who live in rural areas. These rural areas make up 95 per cent of the land area of the county and, importantly, are home to over half of the population of people aged 65 and over.

Historically retirees would move to Lincolnshire – and particularly the coastal regions – to enjoy the fresh air and countryside; and often these people would have spent their working lives in the industrial heartlands of the Midlands. Many of these people will not be in the best of health.

The challenge facing the local authority and the NHS in Lincolnshire is to provide the best care for the whole population, including those who may be in poor health and who live in sparsely populated rural areas.

This care needs to start at home, and it is understandable people want to live in their own home for as long as possible. But if that person is secluded, in a rural area, that can develop in to them being cut-off – and suddenly they are struggling to see friends, get to the shops, or get to the hospital for an outpatient appointment.

This can be a major cause of inequalities in health – especially as we know that if you are also poor you're more likely to suffer from ill health. This combination of rurality and socio-economic deprivation isn't unique to Lincolnshire, but it is one of the defining public health challenges to local government and the NHS.

Every area in the country is currently working to improve health and redesign healthcare. The point is this – rural areas have to think of different ways to do things in order to get the same results as urban areas. Being innovative is key.

In Lincolnshire, we are working towards an integrated transport provision that links people in their homes with the key services they need to live well and to stay healthy.

We have trained fire co-responders so they arrive quickly and can take people to hospital if need be; breaking down some of the barriers caused by distance and rurality. Part of this is about having an 'asset-based' perspective – always focussing on what we can do, not what we can't do.

The challenge is to connect these communities, and keep people safe, well and active in their own homes, able to access all the services they need. Local government can lead in innovation regarding transporting people to these services, but it also has a place working with the NHS to bring services closer to people.

In Lincolnshire, we are aware that people want to use high quality health services that are close to home; it doesn't make sense to ask frail elderly people to travel for hours to a major hospital if what they need can be delivered in their local community, or even in their home.

Technology will be a key enabler in this area. Care and management of long-term conditions can be supported by online consultations via easy and accessible video call technology such as skype, and self-care can be made easier by taking advantage of technology.

There are real opportunities for innovation and further integration of public health in Lincolnshire. It should be embedded within areas such as highways, economy, and environment and it is local government that is best placed to steer and guide the whole public sector to make sure that these opportunities are seized.

"We in local government focus on the local context to ensure we are best placed to address and change things that make it difficult for people to live the lives they want."

"Every area in the country is currently working to improve health and redesign healthcare. The point is this – rural areas have to think of different ways to do things in order to get the same results as urban areas. Being innovative is key."

Impact of public health reforms on local government

Councillor Dave Shields
Cabinet Member for Health and Community Safety, Southampton City Council

It is over five years since the transfer of responsibility and funding from the NHS to upper-tier local authorities in England for the delivery of a range of – many mandated – public health functions. As lead cabinet member with responsibility for public health in Southampton since 2013 I feel able to make some observations based on local experience.

Transitional challenges and managing local expectation

Despite having had a joint director of public health appointment between the city council and a coterminous Primary Care Trust (PCT) and the existence of a (non-statutory) citywide health and wellbeing partnership for several years, most local politicians, Council managers, clinicians, public health specialists, commissioners and community health service providers were culturally under-prepared for the changes which took place.

The ring-fenced public health grant and a requirement to deliver a range of mandated services (with an expectation that the lion's share of local drug treatment and prevention services would also be financed though this route) left little scope for innovation in the first few years as many services and contracts were 'novated', primarily from local NHS provider organisations which themselves were still adjusting to life in the aftermath of the transforming community services migration from PCTs.

Approximately 15 per cent of the income of one of our local NHS community health providers derived from the local authority public health grant – creating an inter-dependency both to the NHS and the city council.

Southampton's baseline funding was arguably set at £1 million below its 'equity' target and this, combined with big reductions in local government revenue grant due to austerity and – in 2015 – the George Osborne budget clawback, placed enormous pressures on the public health grant as and when contracts for key local services expired.

This introduced additional tension to the local system with councillors increasingly keen to use the public health grant to mitigate pressures on key service areas impacting on community wellbeing (eg Sure Start children's centres, prevention and early intervention) on one hand and the NHS wanting to protect clinically-led services. There were particular challenges with (re)commissioning of local sexual health, recommissioning misuse, behaviour change and 0-19s services.

We also had issues with how to reconcile different council and NHS expectations. There was a presumption, especially by NHS clinicians, that local public health investment should be driven by the evidence of effectiveness rather than heed 'lay' public/ political opinion and sentiment. This has arguably prevented progress locally towards introducing a local fluoridation scheme and left unchallenged a reliance on commercial manufacturers of health-damaging sugar products in the co-production of family and community-based leisure/ sports promotions.

On the plus side there has been a growing awareness among local councillors about the merits of a public health-led approach in areas like tackling poor air quality and fuel poverty, emphasising transport modal shift or putting greater emphasis on harm-reduction for drug policies and restorative practices for youth offending.

Interestingly one of the key – unlooked for – drivers of a change in political culture has been the city council's scrutiny process both through an excellently led and well-informed Health Overview and Scrutiny Panel (HOSP) and a series of local commissions/ scrutiny inquiries that have really helped shape local system thinking and policy – with influential public health leadership – in the following areas:

- a fairer Southampton – focusing on fairer employment, living and communities
- Health & Homelessness Scrutiny Panel (HOSP)
- clean air scrutiny panel inquiry
- a dementia-friendly city scrutiny panel inquiry
- tackling loneliness and isolation scrutiny panel inquiry
- addressing drug-related litter scrutiny panel inquiry.

Oddly enough the role of the health and wellbeing board (which I chair) during the first few years has tended to focus rather more on local service integration and improved joint commissioning using opportunities presented by the Better Care Fund.

Challenges and opportunities going into the next Spending Review

Further cuts in council budgets and the impact of other austerity measures are clearly beginning to impact negatively on health inequality, and councils' limited public health funding will be used increasingly to address secondary prevention (the symptoms) rather than the underlying causes that might best be tackled through more (targeted) universalism and population health approaches.

A key first step here would be for central government – as part of its forthcoming spending review – reverse the £600 million cut in councils' public health budget. In addition government should consider the vital contribution of local authorities to community wellbeing and recognise the valuable contribution of the full range of council services (and those delivered through public sector organisations and wider civil society) towards community wellbeing.

In recognising and valuing the contribution of local government to improved public health, government needs to ensure continued availability of the public health grant with financial safeguards applied at a local level through additional and enhanced powers for health and wellbeing boards. Assigning responsibility for local public health funding to NHS England or through untested and top-down integrated care systems would detract from the important role played by democratically elected local councillors as legitimate place leaders and stewards.

> "One of the key drivers of a change in political culture has been the city council's scrutiny process both through an excellently led and well-informed Health Overview and Scrutiny Panel and a series of local commissions/ scrutiny inquiries that have really helped shape local system thinking and policy."

Working together to turn the tide on the HIV epidemic

Debbie Laycock,
Head of Policy and Public Affairs, Terrence Higgins Trust

2013 seems like a distant memory. The amount of change that has happened in that time – both positive and challenging – is incredible.

In our HIV and sexual health world it has taken a long time for the Lansley reforms to bed down (excuse the pun)! The Health and Social Care Act was not kind to our sector – splitting services and dividing responsibility for pathways across many commissioners.

The move of public health to local authorities was a positive one – we all know ill-health is driven by broader social determinants of health – and the desire from local government to focus upstream and understand what facilitates good sexual health was welcome.

However, the reality since 2013 has been mixed and not been without its problems. Some local authorities stepped up to mark – even over it, whilst others lagged behind. We would all agree I am sure that local authorities are diverse beings – they can't not be as their geography and political priorities cover a vast spectrum of identities. Whilst some local authorities have embraced responsibility for sexual health and HIV prevention – leading the way with intelligent, supportive commissioning, others were slow to grasp the detail and commissioned services that did not reflect local need.

Disagreements on who was responsible for what slowed down implementation of innovative interventions – the case of the HIV prevention pill – PrEP – going all the way to the High Court to decide who should fund it – is a case in point.

And then the cuts from national government came. The Health Foundation believes that sexual health budgets will have been cut by 25 per cent between 2014/15 and 2019/20[13]. This is not unique – other public health interventions have been hit just as hard –and in some cases harder. It is frustrating that just as many local authorities were getting in their stride of understanding their new responsibilities, funding cuts meant that they were never given a chance to truly flourish.

But through all this, there have been directors of public health, commissioners, sexual health and HIV frontline staff and councillors who have doubled down and been the driving force in making progress on HIV locally.

We have a lot to collectively celebrate – HIV rates are down 17 per cent since 2016 and have halved in gay and bisexual men since 2012[14], as a country we have met the United Nations 90-90-90 target on HIV, and we are leading the way globally on how we end new HIV transmissions.

It has taken the whole system working together – local authorities, NHS England, clinical commissioning groups, health professionals, charity and community groups, academics, Public Health England – to make this progress happen and we should perhaps reflect a bit more on this rich melting pot of resources we jointly have.

13 http://reader.health.org.uk/taking-our-health-for-granted
14 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759408/HIV_annual_report_2018.pdf

Looking in my crystal ball for the next six years – who knows what the current turbulent times hold for us. But these are the three things that we would like to see:

1. directors of public health become activists – to continue to step up their advocacy and influencing on national policy decisions that affect public health – to fight the continued cuts to public health services, fully engage in the Government's departmental spending review and highlight the devastating impact that cuts are having on local communities and local constituents.

2. Local authorities to continue to embrace the opportunity we have to end new HIV infections in England. It will continue to take all of us to make this a reality. But local authorities are perfectly placed to drive the last push to end the HIV epidemic – to implement innovative ways to test for HIV and PrEP – to tackle undiagnosed HIV. But also to share and support those local authorities that are struggling to make the kind of progress on HIV that places like London have been able to make. We will not get to zero new HIV infections in England unless we bring the whole country – all local authorities - along with us.

3. and finally, we would like local authorities to continue to embrace the positive force that is local communities. To fully embrace community engagement in services, codesigning HIV and sexual health services that work for local people, and welcoming community delivery of services, especially to reach those people we are not trying hard enough to reach.

The last six years has been a rocky road, but with some incredible achievements made along the way. Funding cuts will not make the next six years easy to say the least, but working together we are without a doubt a hell of a lot stronger.

"It has taken the whole system working together – local authorities, NHS England, clinical commissioning groups, health professionals, charity and community groups, academics, Public Health England – to make this progress happen."

A vision for population health: towards a healthier future

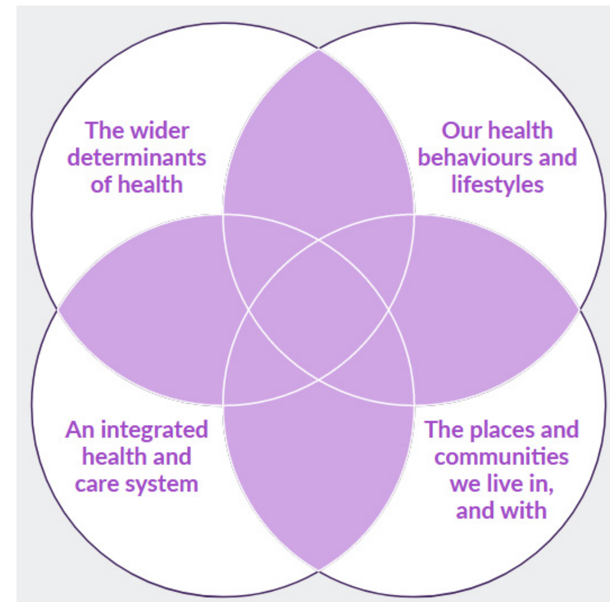
Dave Buck
Senior Fellow, Kings Fund

We are now close to a tipping point, politically, economically and most importantly in terms of the health of the population. The secretary of state has made his priority for prevention clear in 'Prevention is better than cure'[15], and announced a green paper next year, to help inform the Spending Review that is expected. In this context we hope our new vision for population health[16] will help move beyond the tipping point into action.

There is a burning platform, our overall health as a population is stagnating, inequalities in health are widening and our health outcomes are mediocre compared to our main competitors. Investing in and improving the NHS, no matter how important, will not solve this on its own. Therefore, if we are serious about addressing these challenges and improving population health we need to do two critical things.

First, to rebalance resources towards those things we know are the critical things that improve population health, including the wider determinants of health and second, start actually 'act like' a population health system at local, regional and national level.

That second, requires a stronger understanding and action on the connections between the four pillars of population health (the wider determinants, our lifestyles and behaviours, the communities we live in and belong to, and an integrated health and care system) – in other words the policy, activity and outcomes that are based on shared contributions, that populate the 'shaded rose' below.



We share examples of what could be in the rose in the report, for example on how Wigan is changing the relationship between its integrated health and care system and the communities[17] it serves, placing more power in the hands of communities through the 'Wigan Deal'; to how the NHS can do much more to act as an economic engine of growth, social actor and anchor institution in local communities, as it recognises its role as a wider determinant of health, and not just a provider of healthcare services. But this is deliberately set out as a framework, what is in 'the rose' in Sheffield will be different to Cambridge or Portsmouth. Our point is that every area needs to be clear and confident in that what is in its rose, and to know how it contributes to maximising population health.

To enable this, urgent change is required and should be priorities for the green paper and the spending review. National action is required on three things: as a minimum, restoring the real value of the local government public health grant; adopting new binding goals for population health; health impact assessment across government[18]; and a new cross-government health inequalities strategy. On the latter, this should build on the learning from the last one which came to an end in 2010, and we now know made a significant impact on health inequalities[19]. At local level, much stronger local leadership for population health is required. Where that comes from and in what institutions it coalesces in will be different in different places. It may be sustainability transformation partnerships and integrated care systems in some places, or around being a 'Marmot City, as in Coventry[20]. But at the heart must sit strong local political leadership that can bring together all who need to contribute and help make the connections across the pillars of population health.

> "We hope our new vision for population health will help move beyond the tipping point into action."

15 www.gov.uk/government/publications/prevention-is-better-than-cure-our-vision-to-help-you-live-well-for-longer
16 www.kingsfund.org.uk/publications/vision-population-health
17 www.kingsfund.org.uk/audio-video/donna-hall-wigan-story
18 https://publications.parliament.uk/pa/bills/cbill/2017-2019/0198/18198.pdf
19 www.kingsfund.org.uk/blog/2017/08/reducing-inequalities-health-towards-brave-old-world
20 www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city

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