ALL’S WELL THAT ENDS WELL?
LOCAL GOVERNMENT LEADING ON HEALTH IMPROVEMENT
CONTENTS

Foreword 1

Introduction 2

What are the major challenges that local authorities face in the transition and beyond? 4

The way forward 6

Findings 10

Conclusions 23

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The LGiU was commissioned by the Department of Health to carry out an independent study of the role of local government in supporting health improvement and tackling health inequalities, and to analyse the structure of support needed locally to deliver effective action for communities.

The report builds on the work of the Marmot Review in establishing the importance of local activity in tackling the social determinants of health. The main aim is to set out a local government view of what its ambitions are for health improvement and what its support needs are.

All’s Well That Ends Well? was commissioned before the General Election — its prime focus is unchanged, but clearly the context is different following the publication of the health white paper, Equity and Excellence: Liberating the NHS in June 2010. The agenda is, of course, also rapidly evolving, so this report is a contribution to that discussion.

The LGiU interviewed five local authorities — mostly with their health partners, and also interviewed the programme manager for Manchester City Region and Warrington Total Place on their early years project. The councils were Kent County Council, Sheffield and the London Boroughs of Greenwich, Barking and Dagenham and Tower Hamlets. We also hosted a LGID communities of practice session discussing these issues. There were over 50 responses from health, local government, the voluntary sector and consultants working in this field, and these have been drawn on in writing the report.
INTRODUCTION

“The principal objective of the public health department of a local authority is the provision of a healthy environment in order to ward off sickness and ill-health from the inhabitants of its district. Although the provision of hospitals are included among their powers, our local councils are more concerned with the prevention of illness than with their cure.

“Slums are demolished and new houses built; public swimming baths, maternity and child welfare services… these are only some of the tangible achievements of local government, which have revolutionised the health and welfare of the whole population as compared with their grandfathers.”

Walter Elliot, Minister of Health — responsible for local government
The ABC of Local Government, C Kent Wright, 1939

The politics of public health are changing: the coalition government was not slow to set out its policy direction and proposed structural arrangements — the Public Health Service; transfer of responsibilities to local government; the greater emphasis on individual responsibility.

The wider policy context is becoming clearer: targets and national performance indicators are out; the Audit Commission axed; quangos are abolished or slimmed down. Communities and Local Government is dismantling regional structures, ring-fencing and the performance framework for local government.

The government, in proposing to transfer public health responsibilities to local authorities clearly recognises local government’s core role in promoting public health and tackling health inequalities. Shared responsibilities are the key — across central government and with local government, and indeed with communities and individuals. Of course, this rhetoric is not new, but the plans for implementation are certainly ambitious and different. Local government may be getting back some of its role in public health that was lost in 1948.

There are still big questions for local government — around accountabilities; the role of regulation and national agencies; and how local government will relate to the Public Health Service. These will not be fully answered until the Public Health White Paper is published,
probably in December 2010. The public health white paper will be crucial both politically and organisationally.

What is clear, however, is that local government is facing a huge task; taking on new roles at a time of unprecedented financial pressures, within a very tight timescale. Councils will need support to manage what could be a difficult transition. They will have to find ways of navigating through complex political and organisational challenges, and local government needs to be agile enough to respond positively.

There will be ongoing debate about policy responses to the growing health inequalities gap. The public health white paper may clarify the government’s approach, but it is already apparent that there will be renewed emphasis on personal responsibility for changing lifestyles, whilst recognising the underlying causes of health inequalities and the ways in which individual lifestyles are influenced by the wider physical, social and economic environment — “the interdependence of places and people”, as described by Professor Danny Dorling. Local government is in a unique place to bring together the two strands.
WHAT ARE THE MAJOR CHALLENGES THAT LOCAL AUTHORITIES FACE IN THE TRANSITION AND BEYOND?

Local authorities are having to respond to a rapidly changing policy landscape and to a deteriorating financial one. Taking on new responsibilities at a time of unprecedented public spending cuts is a huge challenge.

There are major opportunities for local government in the transfer of public health responsibilities to local authorities, but also significant risks.

The transition to the new system is bound to be problematic. Some of the councils we interviewed are already starting to build closer relationships with local GPs and stronger links with public health. But uncertainty adds to the challenge. How can councils and their partners that are ahead of the game maintain their focus on tackling health inequalities and on improvement whilst the NHS is undergoing huge structural reforms and local government is having to develop its own new roles — fragmented services could get worse, at least in the short term. What about those councils who have not focused on this agenda?

Until the publication of the public health white paper, local authorities will not be clear what the scale or the scope of the public health funding to be held by the Public Health Service is going to be or how much of the budget will go over to local authorities. Getting the right balance in the relationship between local government and the new Public Health Service is critical.

The health inequalities gap has got worse despite the priority given to tackling it by the previous government. Councils will be expected to deliver better results (and may be rewarded for doing so through a health premium) when finances are squeezed across all services and sectors.

The research for this report tells us that councils cannot begin to deal effectively with health improvement and tackling health inequalities unless they have strong partnerships. Being able to join resources with other agencies is going to be even more crucial when budgets are slashed. It looks like the coalition is committed to some form of place based budgets. There may be greater funding flexibility to meet local priorities and to pool budgets across the public sector, but there is no guarantee that the new community budgets will incorporate much beyond local government budgets and in any case they are only being piloted at this stage.
All the councils visited for this research stressed again and again the need to focus on preventative action. How can there be a lasting shift to prevention when the public sector has to deliver quick cuts and fund services that are already at breaking point for those most at risk, such as adult social care, and will be expected to do so at a time of severe finance restraint?

Given the challenges of the reform agenda, central and local government will need to prioritise support for local authorities in taking on new roles. The councils we talked to are in a very good place to respond positively, but many others will be much further behind the game. There is going to be a sharp reduction in funding for improvement across government — particularly difficult timing given the need to increase capacity across local government.

Our discussions with councils highlighted where there are common concerns, such as how to develop relationships with GP consortia, ensuring GPs are fully integrated into partnerships and are working across boundaries; and how GP commissioning and local authorities commissioning public health will fit together. Greater coterminosity between health and local authorities has been positive and council officers expressed worries about the uncertainty over the future geographical boundaries of GP consortia — with the government saying currently that it will be up to GPs to decide.

There is a real concern for councils that GP consortia should recognise their own role in improving public health, even though the main responsibility has been transferred to local authorities. Experience has shown that coterminosity facilitates greater sharing of data, greater integrated commissioning and service provision and, therefore, better outcomes for people.

Developing a more robust evidence base for actions and investment and avoiding endless and inefficient duplication were other real concerns.

Local authorities have been active in trying to strengthen the accountability of health locally, through health overview and scrutiny committees and the involvement of health in local strategic partnerships. Some have gone further, such as Kent County Council’s local healthwatch scheme. But there will need to be a big leap in building the capacity of local people and communities if they are to be effectively involved in health and well-being matters, and to ensure local bodies, including the health and well-being boards are accountable to them.

Will councils have the powers, resources, authority and desire to effectively take on their new leadership role in public health? As well as delivering their part of the public health service, councils will need to develop political and organisational structures that can effectively strengthen the accountability of local health services, whilst promoting integration across health, public health and adult social care. The councils we interviewed relish the challenge, but no-one is pretending that they can do it on their own.
THE WAY FORWARD

This section draws out the key recommendations in the report around the future arrangements for improving health and well-being outcomes at the local level. There are more specific principles for action listed under the findings section of the report.

Funding

The government has said that a ring-fenced public health budget will be transferred to local government. It is not at all clear yet what the scope or scale of this is. There is a danger that because it is not defined, funding for public health could leak into other areas before the transfer occurs.

The government needs to make explicit what is included within the public health funding stream and what part of the public health budget will be ring-fenced. It should be ring-fenced from now until it is transferred to protect it in the transition period.

The spending review confirmed that the public health budget will indeed be ring-fenced at the local level. Many councils will not be happy about this, but even with ring-fencing, there should be maximum funding discretion, in accordance with the principles of localism, to facilitate efficiencies, joint working and commissioning and pooled budgets.

It is palpably clear (as forcefully reflected in this report) that the contribution of local authorities to improving the health of their residents and to tackling the health inequalities gap is made largely through their mainstream activities. A rigid ring-fencing the public health budget could, perversely, reduce spending on health improvement — particularly given the harsh financial climate — by councils who then see the ring-fenced budget as the sole or main source of funding for public health.

The Supporting People budget was originally ring-fenced but subsequently the ring fence was removed, to give councils more discretion over how the funding could be spent in smarter and more collaborative ways. There should be a review of how ring-fencing the public health budget is working to judge whether the ring-fence should be removed in a similar way.

Public spending decisions across government (and in local authorities and the NHS) should take account of their impact on health inequalities (there could be, for example, impact analysis similar to equalities impact evaluations).
Complex social and health problems require a whole system approach, such as that of the Greater Manchester early years pilots, which recognise the interdependence between early years, health, housing and family services. The government, in developing its policies on community budgets, needs to ensure that all departments understand their role in tackling health inequalities, and that there is co-ordination between departments at the national as well as local level.

All government departments need to recognise the new role of local government in relation to public health and support local authorities in this. The Total Place pilots described in this report highlight the efficiencies and improved outcomes that are possible if new ways of working are developed — making links across sector and organisational boundaries.

The huge pressures on public services over the next few years threaten to undermine the progress that has been made in improving health and well-being by focusing on prevention and early intervention. There are very good examples in this report. Making the business case is increasingly urgent.

Drawing on the work done by Total Place pilots, such as Greater Manchester, there should be models developed that provide robust cost benefit analysis of actions that deliver longer term savings from early intervention and preventative action, so that it is clear where future benefits accrue, and incentives can be provided to one part of the public sector to invest in prevention that results in benefits for the community and savings elsewhere.

**Strong local foundations**

Our research highlighted several common themes that were reflected in those councils that were seen as performing well in this agenda: strong leadership; a long-term commitment (going back over time and into the future); a strategic and whole council approach. Councils like Greenwich make explicit to all departments and staff the relationship of the wider work of the council to health. They link the environment, social and economic sustainability to health and well-being outcomes. They recognise the crucial role of service users and residents in developing policy and the design and delivery of services.

Of course, no-one can legislate for these, but there are clear lessons to be learnt from these councils. Their experiences needs to be preserved and disseminated over the next period, which though exciting from the local authority perspective, is also potentially destabilising and disruptive.

Unsurprisingly, strong partnerships have been fundamental to success in improving health and well-being outcomes in the councils we visited and interviewed. The next section considers how existing partnerships can be maintained and strengthened and new ones developed.

**Effective partnerships under the new arrangements**

Strong partnership working depends on building positive relationships. All of the councils we visited had built close ties with health over some time and with much mutual effort. There will have to be new relationships established and existing ones strengthened, especially with GP commissioners. Mutual learning is needed between local authority members and officers
and public health professionals and education professionals, so that there is a shared understanding of the new political and democratic context in which decisions about public health and well-being priorities will take place.

Although building positive relationships is going to be absolutely critical, there is also a clear need for the new arrangements to be underpinned by a robust legal framework. Many interviewees commented on the lack of effectiveness of the current arrangements, such as LSP health and well-being boards. The proposed health and well-being boards should be statutory bodies: they will need to have effective powers, so that they can deliver strong strategic direction for coordinating health improvement and have real influence on all the participants, with the Joint Strategic Needs Assessment (JSNA) as the main way of identifying the diverse needs of the local population as the basis for local commissioning. There was a feeling among those people we interviewed that the new boards will need powers to ensure the compliance of the new consortia.

Clearly, in order for the boards to be effective and powerful, they will need the authority to take decisions without constant referring back to their nominating organisations. There is a danger, of course, that this could lead to a lack of local accountability. The boards should be subject to independent scrutiny and should include on them a wide range of stakeholders, including strong user representation.

Although there should be a statutory basis for the boards, there has to be flexibility built into the statutory framework so that they reflect local circumstances. There are, for example, clear concerns from district councils about their future role, and they should be represented on the boards. Equally, issues that cross boundaries need to be addressed through boards being able to work together.

Given the consensus that coterminosity at the local level has clear benefits in encouraging joint working and data sharing, there needs to be clearer guidance from the government (indeed, any guidance would be welcome), so that GP practices are encouraged to form consortia that relate to their own local authority boundary or a neighbouring one.

**Supporting improvement**

The improvement agenda is changing across government. Local government, through the LGA, is consulting on sector self-regulation and improvement. Our research suggests that the LGA approach towards improvement across local government is the right way forward for supporting health improvement — in the transition period and beyond. Councils collectively should be taking responsibility for development and performance.

Within this new sector owned approach, all councils will have responsibilities, with the LGA expecting councils to contribute to improvement across local government (and public services more generally) by providing councillor and officer peers and other support to authorities and sharing knowledge and learning through a variety of routes, including communities of practice. The experience of the Healthy Communities community of practice, which is lively and well used, shows that there is scope for using similar vehicles as an important tool.

Councils we interviewed have successfully used the tools and support developed by the LGID (previously the IDeA) in their health improvement and health inequalities work. Peer reviews
of health inequalities work have been important for many councils. In turn, excellent performing councils have been active in sharing good practice.

The Regional Improvement and Efficiency Partnerships (RIEPs) were useful to some of the councils we visited. When RIEPs funding ends, councils should be looking to develop new ways of collaboration across boundaries at different spatial levels — which are likely to take different forms in different areas according to local choice — to take forward these proposals.

Some of the councils we talked to said that there was a particular need for support for councillors, and peer support is especially effective for elected members.

There will continue to be a need for coordination across authorities to provide support and reduce duplication. Local government should take the lead here, working closely with all the relevant stakeholders. There is already far too much duplication: it is crucial that the knowledge built up about improving health outcomes locally and addressing health inequalities does not get lost. The experience of many councils in dealing with the underlying causes of health inequalities across a wide field needs to be captured and the lessons learnt.

With the demise of the national performance framework, peer challenge will be more important. It is essential that this is not a soft option and that different models are developed to suit local circumstances.

Support is not one way only. Local government is in a good place to be able to support others, particularly GP commissioners. Councils like Greenwich that have focused on health improvement and tackling the health inequality gap as a core strategic function of the council have a huge amount of expertise to share. Building capacity and commitment within GP consortia is going to be increasingly important if local commissioning is going to be fit for purpose.
FINDINGS

Funding

The in-year spending cuts announced in May 2010 have affected programmes that directly and indirectly impact on health inequalities, principally the abolition of a number of grant funding programmes and the de ring-fencing of others — this means that previously ring fenced monies can now be used more widely, but could also result in funding being moved to other priorities. In Sheffield, for example, they have reviewed their health inequalities action plan — they felt that they had to do a reality check on their proposals with the loss of area based grants.

There has been a heavy reliance on dedicated funding for pilot or time-limited programmes. A number of small initiatives, although delivering positive results, will not be enough to deliver the wholesale changes that are needed in some areas, particularly where there is serious deprivation. Barking and Dagenham, for example, made a clear strategic decision to develop ‘industrial level change’ where previously they had focused on a number of smaller initiatives that led to pockets of good practice, but had not been comprehensive or transformational.

There was a feeling that having to respond to a series of government initiatives meant that sometimes programmes were not embedded in properly before the next one arrived, and that serious evaluation was undermined.

Short-term funding programmes can, of course, work well — particularly those where the programmes have been joint ones with health and build on the council’s strategic priorities, although there is still often a problem at the end of the funding period. Councils also developed local programmes to fill gaps where national ones did not address particular circumstances, such as Sheffield’s work with incapacity benefit recipients to provide skills so that the national DWP Condition Management Programme for these claimants would be more effective locally.

One of the councils stressed that there was never enough funding to stimulate new ideas and innovation.

The transfer of the public health budget should mean that longer term planning and integration are easier to deliver.

There were mixed views about the impact of cuts to mainstream budgets. On the one hand, health promotion related work was seen to be no more at risk than other services; they all
have to rationalise and demonstrate value for money. Programmes that are embedded into partnerships and have strong foundations are much more likely to survive. However, it could mean some services or partners are unable to take part in activities that are not seen as core. For example, it may make it more difficult for youth services to find resources to take part in initiatives if they consider health inequalities to be an add-on and not core to their work.

Total Place highlighted the efficiencies and improved outcomes that can be achieved through developing new ways of working, connecting strategic decision-makers into action at a very local level. The Kent pilot linking housing, mental health and employment shows how making the links between health and wider services improves delivery, whilst increasing cost effectiveness. The Greater Manchester early years pilots involved a thematic group with members from health and the Association of Greater Manchester Authorities health commission to share learning, remove blockages to delivery and develop shared measurable outcomes.

The councils visited are planning for, or are already dealing with, significant budget reductions. Much of their work is focused on prevention and early intervention — there is concern that across the public sector, there will be cuts here, unless the economic case for them is robustly made. There will have to be hard evidence of the effectiveness of early intervention and preventative action to add to what already exists.

Some areas have been developing their own models: the Greater Manchester early years project is establishing a cost benefit analysis model for measuring the effectiveness of interventions with a specific economic focus to determine whether early intervention does deliver cashable savings down the line.

Similar models are being developed elsewhere, such as Birmingham’s analysis of their early years partnership initiative that should deliver savings over 15 years across public services. Birmingham, like Manchester, has developed a systematic approach to multi-dimensional evidence, starting with collaboration, strong evidence based interventions and whole life costings.

There are no national models that incentivise public sector bodies to invest in programmes that deliver financial benefits elsewhere over time. To make models like Manchester’s work across local government, there should be financial rewards for councils investing in early intervention models, such as the early years pilots, or in family intervention that produces, for example, savings down the line to the NHS and to the Ministry of Justice.

There was discussion about whether the public health budget should be ring-fenced at the local level when it was transferred. The majority felt that it should not be: even without ring-fencing, the budget would be ‘protected’ by local authorities being expected to deliver improved health and well-being outcomes, and, more importantly, by councils recognising the importance of promoting health, and establishing clear corporate objectives to do so.

Ring-fencing would reduce the flexibility necessary to respond to local conditions and to join up with partners in achieving shared objectives. There is a danger that the DH will impose heavy conditions on the use of the public health budget locally that would see it being used in a narrow way.

Councils stressed, however, that the funding should be ring-fenced in the transition period to prevent it from ‘leaking’: potentially more likely given the lack of clarity over what is currently spent on health improvement and tackling health inequalities.
Recommendations

- The public health budget should be clearly identified, audited and ring-fenced now until it is transferred to local government to protect it in the transition period.

- There should be a protocol agreed between the DH and the LGA on the criteria for transfer — what funding is transferred and by what criteria and how it will be done.

- If the public health budget is to be ring-fenced once transferred then, when local authorities take over the public health function and budget, there should be maximum funding discretion to facilitate joint working and commissioning and pooled and aligned budgets.

- Time limited funding for specific initiatives should be replaced, wherever possible, by mainstream funding, to ensure more sustainable development. There also needs to be consideration of the transition process and how existing projects can be integrated into core work or be phased out.

- There should be ways of funding new ideas and innovative practice, and to translate research into delivery.

- Partners should work at achieving objectives for shared outcomes, (rather than shared targets), where investment would flow into achieving them, particularly if the public health money is included in place based budgets.

- The evidence that exists of the economic (and social and health) case for early intervention (eg from the Total Place pilots, POPPs and models drawn up by PCTs) should be extended, reviewed and disseminated.

- There should be models developed that provide robust cost benefit analysis of actions that deliver longer term savings from early intervention, so that it is clear where future benefits accrue, and incentives can be provided to one part of the public sector to invest in prevention that results in savings elsewhere sometimes far in the future. The government should develop new financial models that benefit local government, the NHS and central government departments that invest in programmes that deliver financial benefits to other organisations further down the line.
Strong local foundations

While each area is developing its own response to health improvement and to tackling health inequalities based on their particular circumstances, the Marmot review has significantly influenced the strategic approach to tackling health inequalities. The principles of proportionate universalism and the six policy objectives were cited as shaping strategies and plans for health inequalities. There were a number of common themes based on strong political and managerial leadership, with a long term commitment (historically and into the future) in several of the council areas interviewed. Health inequalities were clearly seen strategically, not just as a series of projects. Councils like Sheffield and Greenwich have been focusing on building healthy and resilient communities for decades, since deindustrialisation in the 1980s. These councils have taken seriously the duty to promote social, economic and environmental well-being.

In those councils that have focused on health and well-being, there is a clear and explicit acknowledgement across the council that everyone has a role and understands the vision of the council. This is obviously not universal — not every council takes a holistic view of health and well-being.

In Tower Hamlets health outcomes are, for example, now a key part of the planning system—they have been integrated into the core strategy of the Local Development Framework, which states, for example, that there should not be an over concentration of unhealthy shops: the council works with businesses to promote healthy food displays and environmental health tackle customer health as well as the usual safety work.

In Sheffield, the importance given to health improvement in the council and PCT is reflected from the top corporate level to the local community one. The LSP in Sheffield takes the strategic lead on the health improvement plan — the cabinet and non-executive PCT board hold joint meetings. There is a joint director of public health, public health consultants with joint positions and there are public health teams and champions within departments. Community assemblies review the health plan.

There has been considerable progress in Barking and Dagenham in consolidating and strengthening their health improvement work, following a critical CAA report. A defining change has been the development of strong partnership working, where previous top level relationships had been strained.

The focus on public health and health inequalities was not only a council commitment for those interviewed, but was a priority for the local strategic partnership as a whole. This was characterised by joint strategies, boards for reviewing progress and joint appointments. In Greenwich the projects centred on healthy communities were nearly all jointly commissioned with the PCT.

Tower Hamlets has seen the gap in life expectancy narrow. Success in Tower Hamlets is based on the coherence of the health and well-being strategy; strong partnerships based on shared objectives and commitment to joint working from the top were crucial. It was stressed, however, that it has taken four to five years from developing the strategy to practice. In all the councils, partnership is the backbone to their work, and they can rely on any new developments effectively getting a joint response. In Kent, the health improvement action plan and strategy are integrated into the LSP, and the districts are involved through the health and well-being board sub-group.
Strong political leadership is critical, but though all the areas visited reflected commitment from elected leaders, some felt that there was not active involvement from members in general in these issues.

There was a discussion with the interviewees in Sheffield about the relative importance of having shared targets. For the employment programmes, improving health is an added benefit. This is not necessarily the main driver, rather it is seen as a barrier which needs to be addressed in order to get people into work.

The NHS supports employment programmes because being in work is good for people’s health and well-being. It seems that, while a health focus is important at the strategic level, it is not always an added driver for those delivering the service to know they are also meeting health outcomes. However, the team in Tower Hamlets did feel it was good for morale to make these links.

In Greenwich, the relationship of the wider work of the council to health has been made explicit to all council departments and staff. Departments, in turn, have developed their own policies in this context, and are constantly looking at what more they can do. The council runs a health improvement course for staff across the council, not just health and social care. The model is being shared outside the borough — for example with all 25 councils in the North-East via the North-East Healthy Learning Network.

Councillors interviewed use staff flexibly, such as floating housing support workers who have been trained in health promotion to level one. Greenwich saw all frontline workers as being able to signpost and support local people to know about and access services that can improve their mental and physical health and well-being.

Greenwich highlighted the importance of place and the environment, reflected in their health and well-being strategy, with projects such as ‘Feeling good about where you live’ and the ‘Healthy Urban Planning Framework’, and in developing public policy which recognises the interdependence of the physical, social and natural environments to support health and well-being.

The councils visited gave priority to engaging communities and residents in promoting health and well-being, and in ensuring that service users and communities are involved in service design and delivery. Greenwich’s health and well-being strategy stresses that “staying connected with others, keeping on learning throughout life and giving something back to society are all known to have a positive impact on mental well-being”. Tower Hamlets use participatory budgeting with funding from the council and PCT for local communities to prioritise spending to tackle health challenges in their areas. The council also funds small resident-led projects that focus on growing food in urban areas.

Kent has a particular focus on building resilient communities, taking a co-production approach — building in the contribution of individuals and communities to service planning and delivery. Co-production models should deliver services that are better targeted, more sensitive to local needs and more cost effective.

Greater Manchester authorities want to enable communities to support themselves, to reduce demand for services and promote self-reliance. All of the councils interviewed understood the importance of identifying community assets and strengths, such as skills and knowledge, to build community capacity, mutual support and social cohesion.
As the national agenda continues to change, local areas understand that this will affect their approach. Current ways of working in the councils interviewed can fit well with government policy priorities. In Kent they have a strong social marketing approach and feel that there should be more emphasis on lifestyle rather than access to health services. In Barking and Dagenham, the joint council and PCT project to increase physical activity and promote healthy eating in children through using smart cards involves close working with the voluntary sector, the private sector and schools — a Big Society project in action.

Kent County Council were first to establish an independent democratic accountability structure through Kent Health Watch. The coalition’s proposal for Local Health Watch is similar, but will be on a statutory basis and should give it more teeth.

Recommendations

- Social, environmental and economic sustainability should be central to national and local policies that address health improvement and health inequalities.

- Public spending decisions across government (and in local authorities and the NHS) should take account of their impact on health inequalities.

- The principles of co-production — that is, service users and individuals being seen as partners in the design and delivery of services — should be integral to tackling health inequalities.

- Councillors, including non-executive members, need to be fully engaged in the new public health agenda, so that it is seen as a core part of the council’s work and not just something else the council does. Councillors will require specific support to take on their enhanced roles.
Effective partnerships under the new arrangements

All of the councils we talked to had built strong relationships with health locally, but there are also partnerships across the wider public sector, such as Sheffield’s with the DWP, which focuses on worklessness and people on incapacity benefit.

There was concern expressed by some of the interviewees in two of the councils that partnerships can actually be too strategic, losing direction and effectiveness at the front line.

There are also important cross boundary relationships that can share learning and provide support and guidance. In Greater Manchester, for example, they have found a multi-agency approach from pregnancy to school age is crucial.

There were many positive examples of councils and partners developing new ways of working and engaging with vulnerable families — in Greater Manchester early years work, it was clear that the greatest engagement with families and very young children has been primarily medical, which did not help to identify those with most risk of becoming dependent and does not provide sufficient incentives to engagement with families in most need. A much more holistic and cross agency approach has been adopted to help families to access appropriate support earlier and to become more self-reliant.

The particular circumstances in two-tier areas did not feature a great deal in our council visits (which were in unitary areas, except for Kent), but this was clearly an issue in the Healthy Communities COP online discussion. There can be positive relationships and joint working in two-tier areas on health related issues, there can be a gap, however, between identifying need and service delivery, particularly in relation to housing. The position of environmental health was also mentioned — where should environmental health sit in two-tier areas when the new public health service is established in upper tier authorities?

The contribution of districts to the health and well-being of their communities is bound to be an increasingly important issue once the new arrangements for public health are in place and upper tier authorities are responsible for the new health and well-being boards. There has, for example, been increasing recognition of the role of spatial planning in promoting healthy communities (reflected in Tower Hamlets and Greenwich for example). The JSNA should support the sustainable communities strategy which is aligned with the Local Development Framework. The links that have been established between planning and public health should not be lost in the new regime.

Although there is commitment from health at the highest level, this is sometimes not reflected in practice, especially from health service professionals. Some councils felt that professional identity issues could create barriers to developing a more holistic approach to service delivery.

There was concern expressed that the relationships that have been built up over time (and not easily) with PCTs will be hard to establish with GPs. There have been some bad experiences from attempted partnerships in the past. Although, some interviewees were fairly optimistic that GPs are already involved in the joint working around health promotion, they felt GP commissioning could make it more difficult to ensure equity across the council. There could also be major problems about the lack of coterminosity. Some interviewees felt that there was a danger that public health could be sidelined by the new consortia.
There was a view that having GP consortia represented on the new health and well-being boards would not be enough in itself to ensure closer partnership working, and that the boards will need additional powers in order to ensure GP commissioners are fully committed to working cooperatively on the health and well-being priorities for the area highlighted in the JSNA.

Experience of other partnerships, however, would suggest that structural change will not work effectively without cultural change happening alongside it. Doubts were expressed about the understanding of GPs of the wide health and well-being needs of the whole population, not just those they see. It is clearly too early to judge whether it will be easier for those areas, like the ones in this study, that have developed close relationships with PCTs, to build up future relationships with GPs, than those that haven’t.

Greenwich is, however, already establishing stronger links with local GPs, inviting them into meetings at the council. Councils outside the scope of this study are also pressing ahead: Blackburn with Darwen Council and PCT, for example, are working with GPs to ensure that health commissioning will continue to address the whole health agenda including health inequalities. Their approach is based on the principles promoted in the Marmot review.

There were examples of GPs taking a broader approach to healthcare, notably in Tower Hamlets, with the Bromley by Bow centre which through a partnership between the private, public and voluntary sectors, serves thousands of people in east London with more than 100 community projects, a GP practice and social enterprises providing everything from landscape gardening to leadership classes.

Dr Sam Everington is at the heart of the centre, working as a GP in its surgery and supporting many of the other projects within the centre. Developing this kind of community focus on health and well-being, with GPs taking a central role, will be essential if the new arrangements are to enhance, not weaken, health improvement locally.

Where a council has a strong relationship with PCT staff who have a public health responsibility, the new public health function within the authority will be based on firmer foundations, particularly if those staff transfer to the local authority.

It is not yet known what the arrangements will be for staff working under the Directors of Public Health for transfer to local authorities, but there is a view among some councils visited that transferring as many of possible of the team is preferable, although some specialist functions could be better placed in the national public health service. Clearly, councils will vary in their views over this and there needs to be negotiation at the local level over transfer of staff, and reassurance from the centre that transferred staff will be properly funded.

Several interviewees — from councils and PCTs — stressed the importance of Directors of Public Health being an executive director level post, so that they have sufficient influence within the council as a whole. The experience of the joint posts (with 80 per cent of DPHs being joint posts) would suggest that they do not have executive posts currently. Some officers from health and local government felt that the DPH should be appointed by the local authority and not be a joint appointment as proposed.

How accountability will be managed will be critical to the new arrangements — the existing non statutory boards are often weak. The new health and well-being boards are going to take
on a complex mix of responsibilities: providing scrutiny and democratic legitimacy; strengthening public involvement; and bringing together strategic commissioning of health, public health and social care. Although LSP health and well-being type partnership boards seemed to be working well in the areas visited, it is clear that this is not universally the case, and, anyway, the new local authority co-ordination and accountability responsibilities will require much stronger structures and arrangements.

There was consensus that the new boards needed statutory underpinning, with strong powers to ensure that they can deliver local leadership and a strategic framework for coordination and health improvement locally.

Councils will be taking on a more strongly defined new role in addressing the health democratic deficit locally; robust local leadership will be essential.

**Recommendations**

- Different organisations will not necessarily understand the culture and language of others, such as new GP consortia understanding how local democratic accountability works, or councillors not being familiar with the public health profession. Creative ways of establishing shared learning is required.

- Councils will need to think about how to build effective mutually supportive partnerships with GP consortia as they are developed and not only after they exist, and councils should be engaged with the process of setting up GP consortia shadowing arrangements.

- Councils will need adequate funding, powers and structures to make accountability work. The proposed new local health and well-being boards which will bring together all the local bodies which impact on health, both “upstream” and “downstream” should be statutory bodies: they will need to have effective powers so that they can deliver strong strategic direction and have real influence on all the participants. There needs to be flexibility built into the statutory framework so that the boards reflect local circumstances.

- The strengths of existing partnerships should not be lost, such as cross authority cooperation. There needs to be clarity as soon as possible on how the new boards will work in areas like Greater Manchester with existing cross-authority arrangements, and what the arrangements will look like in two-tier areas.

- The contribution that district councils make to health improvement and tackling health inequalities should be recognised in the new structural arrangements, in funding for improvement and support, and in distributing the health premium.
Supporting improvement

The councils visited used a mix of national sources and locally obtained data. Highlighted data sources included: NICE guidance; Foresight evidence; National Child Measurement Scheme; DPH reports; employment data; local health profiles; Tell Us survey. Local research methods included: residents perceptions survey; citizens panels; commissioned university research projects; health impact assessments. Independent evaluation was carried out by different bodies, including universities, LGID peer review, national support teams and the Audit Commission.

Kent felt that the same information was often gathered by different organisations, such as the county, districts, DWP and health. There needed to be much more coordination and linking information, or joint evidence and data sourcing. PCTs generally invested heavily in social marketing and behaviour change — again it would be preferable to have joint information and intelligence, even though information is shared. Information could sometimes be much more targeted — for example, prisoners leaving prison tended to move to Thanet — trends should be identified and knowledge shared.

Successful local programmes started with clarity over objectives and good baseline data. The JSNA was seen as a strong tool, if used well, for understanding the local population, the links between geography, poor health and access to services, and for evidence for effective targeting.

There were good examples of strong collaboration delivering a robust JSNA and of an open process, such as in Greenwich where as part of the JSNA process, a number of stakeholder voice events were held to gain insights into the emerging priorities from local people, patients, service users, clinicians and other staff.

Evidence from the JSNA showed men’s health in the borough was not improving as much as women’s health was and this was then a focus for intervention. The council and PCT are going further through their partnership information and intelligence group to ensure that the information they have is transparent to the PCT and to plug any gaps in knowledge.

Sharing information and access to data were common problems. Data sharing protocols are very complicated and patchy. Greater Manchester stressed that a more consistent way of sharing data with health partners across the region is clearly needed.

There was evidence of progress: Greater Manchester had a member from the DH Children Health Improvement Programme (CHIPs) on their steering group, which has been a great help, for example, in getting data from A&E and in pointing out issues they may not have been taken into account, and in not reinventing wheels. The programme director for the NWegov group is also very useful in tackling data sharing issues between health and local government, interpreting complex protocols and getting access to data, such as live birth data.

Several councils mentioned the need to have information below super output area and district level, to understand what is happening at the very local level where there may be very different health outcomes within a district, in particular difference in life expectancy. For instance deprivation in Sevenoaks is masked because it is broadly an affluent area.

A joint Barking and Dagenham Council and NHS Barking and Dagenham project illustrates how innovative and creative use of data and technology can improve the health and well-being of children and young people in the borough. A major project, based on an integrated...
youth card, Street Base Connect, aims to improve data collection, incentivise behaviour change and increase physical activity and healthy eating.

For the first time in the UK, young people are able to use a swipe card to access a range of services, such as borrowing a library book, buying their school lunch, visiting the local swimming pool or getting access to free and confidential health advice and support. By taking positive actions like choosing healthier meals in their school lunch, taking part in sporting activities or volunteering for charities, the card holders will earn reward points that they can trade in for awards, such as gym passes.

When the scheme covers all children in the borough, it will be able to track behaviour change on a very large scale. The scheme is already increasing participation in a wide range of services. It can identify which groups are not using the cards and will provide the information needed to target social marketing more efficiently.

Improving activity and participation will eventually reduce demand for medical intervention and according to the PCT will give health professionals the flexibility to take action such as formally prescribing physical activity.

**Support needs**

Future support and learning needs were discussed with the councils interviewed, and this was a major topic in the COP discussion. Councils will require substantial support, starting in the transition period. Where will support be needed to build capacity and how should it be provided? Key areas are sharing good practice and developing networks; developing shared understanding of new areas, such as GP commissioning and the local authority role in this; building local leadership; developing innovative solutions; and establishing and analysing evidence on which to base difficult investment decisions.

There will not be a blueprint — areas will vary, but there is valuable experience from partnership working in health and local government and beyond. The learning from the Total Place pilots suggests that it is not primarily about structures, but about people and relationships.

People from the councils and PCTs interviewed and responses to the COP debate suggested different approaches to learning to work together, such as public health staff who hold joint posts could act as brokers between GPs and councils; peer reviews; joint learning for leaders in local authorities and GPs.

DH regional support networks and health observatories have provided valuable support and evidence for action. The councils visited worked closely with the LGID Healthy Communities Programme, developing networks and sharing good practice.

Sources of support varied enormously. Support did often seem to be supporting specific initiatives and not strengthening strategic direction.

There is a need for coordination, but this does not have to be organised by the government — indeed, the feeling was strongly that it should not be. Local government itself, working with partners, including the voluntary sector, should be taking the lead here, through Local Government Improvement and Development. The councils we visited show the potential for the sector to take prime responsibility for improvement.
Evaluation

Sheffield illustrates the difficulties in evaluating complicated interventions, where the focus is, for example, on impacts beyond health, such as an employment project in Sheffield which focuses on people on incapacity benefit — improving health and well-being are added benefits, and low self-esteem and poor health are in themselves barriers to work. Sheffield use a Marmot style basket of proxy indicators: measuring positive work outcomes because we know work improves health. However, there is debate about whether specific health impacts should also be measured in this context.

The difficulties of measuring what works is clearly not just one for local government — the health select committee (Health Inequalities third report 2008-9) highlighted the lack of sound evidence provided by PCTs of what works in tackling health inequalities. There has clearly been insufficient research and evaluation nationally, with programmes sometimes rolled out with no evaluation, and where there has been funding for evaluation, it has often been inadequate.

This will increasingly be a problem when public health responsibilities are transferred to local government, and there will be financial incentives to deliver results: it is hard to isolate what is having an effect on health with so many potentially contributing factors and the impacts can be very long term ones.

There will have to be a clear picture of the health of local communities and robust measurable outcomes in place if councils are to be given financial rewards for delivering improvements. Councils will require the right mix of skills to undertake proper assessment of their strategies and programmes that impact on every aspect of well-being.

In Kent they have a model for developing programmes which uses data to inform the issue and insight from in-depth engagement with local groups, e.g. what is it that prevents people from connecting to resources. They then test and re-test the idea — evaluating the policy concept — if it works, the policy is mainstreamed and the evaluation is used as a basis for service redesign.

There needs to be sustained shared learning and to evolve new ways of learning, beyond the usual report and conference. There was a concern that as policy changed, learning could be lost — GP commissioning, for example, losing the lessons of public health commissioning.

Evaluation needs to track outcomes and shape future services. Funds and programmes tend to be from national schemes and have their own national evaluation. The pilots visited feel that they had a responsibility to share experience. However, these programmes of continuing evaluation and sharing learning are often only available to the participants. They should be open and transparent.

Evaluation of what works and is value for money will be increasingly important with budget cuts, the need for sharper targeting of resources, and inevitably, some decommissioning of services.

Finally, it is clear that scrutiny and overview committees can be a strong source of knowledge and feed into evaluation. Tower Hamlets child obesity review, for example, resulted in the council revising its approach and more effective target intervention. Scrutiny has also been important in focusing on the wider ‘upstream’ issues.
Recommendations

- As well as a more consistent common set of protocols across partners, data protection regulation needs to be revised through legislation for public agencies to enable shared information for agreed purposes.

- Data sources should be reviewed locally to avoid duplication.

- Funding for research into and evaluation of projects should be built into the plans from the beginning.

- Any national public health service held data and evidence need to be easily accessible and sharable at the local level.

- Councils will need people with the authority to access data and the skills to interpret it and to undertake robust assessments of how programmes and proposed policies impact on health and well-being.

- Evaluation models need to be developed that are locally relevant, and findings should be integrated into reviewing and shaping services across the board.

- There needs to be greater clarity about what is being spent on health improvement and on tackling health inequalities, locally and nationally, to enable more effective evaluation and targeting of resources.

- There should be open and easily accessible access to evaluation of local and national programmes and strategies.

- There needs to be much more focused support for the transition to the new arrangements for public health. There will continue to be a need for coordination across authorities to provide support and reduce duplication, which the Public Health Service should be contributing to. Local government, itself, should be taking a lead here.
CONCLUSION

Local government clearly views the transfer of public health and the new responsibilities for local authorities outlined in the health white paper as a unique opportunity to shift the policy and public emphasis from the focus on the medical model of health to health and well-being. The new framework for public health should more effectively bring together the work that councils do to influence health and well-being through their core services and leadership role with the more traditional public health and health improvement focus. The new arrangements, with public health staff moved into local government, should also increase the local authority influence over local healthcare planning and provision.

The councils visited for the study already work in ways that bring these elements together, although it is recognised that most of these councils are regarded as performing excellently in this area. Councils that are working well see health improvement as the responsibility of the whole council. It is not yet clear that government departments outside health and communities recognise equally that they have vital contributions to make. The community budget pilots announced in the spending review partly reflect this, but they seem very tentative. Funding decisions at the national and local levels need to reinforce the interconnectivity of health and well-being policy.

Although the reforms will mean major structural change to the local health landscape, the most problematic issues in the changeover may be cultural, not technical or structural. Building strong relationships with the new GP consortia will be difficult but crucial. Integrating public health into local authorities will also require shared understanding — of public health language and culture and of the new political context in which health related issues will be discussed and priorities decided.

There needs to be sharp focus on what support councils require (and indeed others such as the emerging GP consortia) in the new landscape — in the transition and during implementation.

Given the lack of coherence around DH support for local authorities, the cross government policy direction to channel improvement locally, and the aspiration of local government to lead on support and improvement, it would be logical that the sector nationally through the LGA Group and councils locally take the initiative for transition and adjustment, building on the strengths of partnership working and strategic leadership. This is even more critical given the rapid pace of change and the imminent demise of PCTs.

However, they cannot do this without the necessary financial support from the centre. Transferring the public health function to local authorities on the cheap will be a huge lost opportunity.
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