Event report

Members meeting

Local authorities and public health - what's in store?

13.06.2012

HOSTED BY

LGIU
LOCAL GOVERNMENT INFORMATION UNIT

VENUE

LGIU
22 Woburn Place
London
WC1H 0TB

Kristina Glenn, Chair of London Funders, welcomed 35 representatives of organisations to a discussion of the changes in arrangements for the management and delivery of public health programmes and some insights into specific activity pursuing public health goals in London. She reminded participants that almost all diseases are socially patterned – from mental health problems to cancer. London Funders had called this meeting because the changes in structures for public health could provide opportunities for a refreshed approach to tackling some of the underlying causes of ill-health and will certainly have an impact on all funders concerned with this broad area. All our speakers dwelt on London's continuing health inequality and their passion for tackling it.

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Laurie Thraves, Policy Officer LGIU: an overview of the changes

Laurie placed the focus of his presentation firmly on the social determinants of health, arguing that the current "over-medicalised" vision of the NHS has been damaging, with expensive technology and clinical need trumping less glamorous healthcare provision. For him, public health must include environmental health, clean streets, good housing and more. The Marmot Review articulated the inextricable links between health and social and economic influences.

Although the Marmot Review is ostensibly about health, the most crucial indicators of whether overall levels of health are improving are within the responsibility of local authorities. Place is a crucial part of the picture. There are very close links, for example, between mental well-being and place. Lack of confidence, basic skills and community cohesion are also strongly correlated with ill health. The present government is giving local government a new duty to take steps to improve the health of their local population. In London this duty falls on the boroughs. Laurie noted that this is a simple idea which proves to contain "Byzantine complexity".

Some of this complexity exists at local level: one way local authorities may fulfil their new health improvement duty will be through commissioning public health services but they will also work with clinical commissioning groups and representatives of the NHS Commissioning Board to integrate services. The challenges come more strongly at national and regional level. Public Health England (PHE) is to be established on 1 April 2013 as an Executive Agency of the Department of Health. Its overall mission will be "to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes". It will do this in concert with the health and social care system, and with key delivery partners including Directors of Public Health, local government, the NHS and Police and Crime Commissioners, and by providing expert advice and services and showing national leadership for the public health system.

PHE will, by April 2013, have a national office in London which will act as its service centre and provide national leadership and strategic direction, and support the overall integration and coordination of the public health system. In addition it will set up national centres of expertise and excellence for public health (to concentrate professional, scientific and analytical expertise to deliver a range of services and functions that support front-line public health activities). There will also be geographic hubs which will be part of the national office and act within a national framework: their boundaries are aligned with the four sectors of the NHS Commissioning Board, one of these being London. There will also be units where expert and specialist advice capacity can be deployed "at a level that allows it to understand and respond to local needs and support local leaders to tackle the health challenges they face". These units will be developed from the 25 current health protection units of the Health Protection Agency.

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There is a lot of uncertainty for boroughs in the lack of detail about current proposals. There is no indication of how the 50 local offices of the NHS Commissioning Board will relate to local authorities or the new health and wellbeing boards (HWBs) and how the 25 PHE units will relate to any of these.

For Laurie a critical question is how borough-level Health and Wellbeing Boards can integrate the health service and local communities with borough activity to drive down health inequality. There has been far too much national prescription in the recent past which has undermined local initiative and innovation and this government's approach which encourages local authorities to just "get on with it" feels right, for most people, with the scope for local innovation highly valued. The changes, however, bring public health into a political context (raising concerns about the treatment of specific areas such as sexual health). This also brings it into the timescale of the political cycle too, though results from public health measures can be very long-term.

The move of Public Health Directors to local authorities is one of the changes which have caused concern. Some of the Directors themselves, for example, are unsure about their continuing professional links to the health service. Choices about the deployment of staff are being made too, as to whether they should be grouped in a public health unit or spread across relevant departments. Staff moving from the health service will have markedly different experience of commissioning from their local authority colleagues and while some aspects of health service commissioning are valuable (e.g. an emphasis on the evidence base and a focus on exit strategies) there will be adjustments to be made to the democratic environment of local government.

Opportunities in bringing local government experience to bear on health issues

There is enthusiasm in local government about the role of HWBs and how they can align the social and public health needs of the population to Clinical Commissioning Group (CCG) plans but since HWBs do not have a power of veto over CCG plans, they will need to exercise influencing skills if they are to be effective.

Laurie hopes that the boroughs will put a lot of effort into making the most of these changes and especially in finding ways to make the HWBs work so that the mutual interests of health and local government can be maximised to achieve public health goals and economies. He sees opportunities in bringing local government experience to bear on health issues. Community-based approaches, the involvement of the voluntary sector, and commissioning that is not as top-heavy as that in the NHS, are all contributions local government can make, while the health service's mastery of evidence could bring clarity to how priorities are set.

Laurie's final comment was that tackling long-term problems that influence the wider determinants of health, such as housing, means taking both a short- and long-term approach. Quick wins can build confidence, and enthusiasm, among partners.

The Marmot Review

Throughout this meeting there were references to the ground-breaking Marmot Review. In late 2008 Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, *Fair Society, Healthy Lives*, was published in early 2010, and concluded that reducing health inequalities would require action on six policy objectives:

1. **Give every child the best start in life**
2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill-health prevention.**

Updated findings and much background material can be found on the website of University College London's Institute of Health Equity: http://www.instituteofhealthequity.org/

Kieron Williams, London Borough of Lambeth: the shift to local authority responsibility

Before talking about Lambeth specifically, Kieron stepped back to explore the context. He reminded participants that there is no direct correlation between expenditure on health and health outcomes. The poor showing of U.S. life expectancy in international comparisons, despite its high outlay on health, is a good example. The NHS in all its existence has not improved the gap in health outcomes from poorest to richest. The Marmot Review described inequality in health as both avoidable and unfair and offered some direct advice as to the causes.

"…health inequalities that are avoidable by reasonable means are quite wrong. Putting them right is a matter of social justice." Professor Sir Michael Marmot

For Kieron the move of public health back to local government makes a lot of sense. It was firmly based there for many years and some of the significant jumps in health improvement originated in local authority action. The span of local authority responsibility means that they are well-placed to work on any of Marmot's areas for action (see page 3) and since "health is political", he believes, setting it in a specifically political context makes sense too.

Kieron's slide presentation (see here) provides information on the funding that will be made available to local government for this work, though no decision has yet been released on the split between local authorities. He also provides a breakdown of current commitments from his own borough. Its public health spending is substantially on sexual health and tackling drug abuse. The HWB needs a vision for the transfer of public health, though much time is being absorbed in developing structures and establishing ways of working.

New ways of looking at issues are what is needed. Kieron's example was how Lambeth invests in the quality of its housing but is not explicit that this is intended to improve health. Thus some of the decisions taken about how to work on housing can have a detrimental effect on individual and family health. If health improvement could be factored into aims, then the HWB should be able to influence what is done and how.

This also fits well within the framework of Lambeth as a Cooperative Council. It is clearly proven that substantial and long-term health benefits can be achieved best with community involvement.

In Lambeth, the HWB itself is a relatively small group of people with shared values and effective working practices. They see part of their role in setting the tone of their communication with a wider group and creating an environment in which they can be effective and have wide influence. There

was further discussion about how far the VCS could be equal partners in HWBs with at least one borough representative noting how hard it is for boroughs to get this right: Kieron's comment was that, in his view, local authorities are the "least bad" public bodies in their community engagement.

For Kieron, the HWB is the place where a complex mix of agencies comes together (including national commissioners as well as local ones). This is also potentially the mechanism to link vital small community organisations in to public sector structures.

Dr Helen Walters, Programme Director, London Health Improvement Board: how the board is developing (see Helen's slides here).

The London Health Improvement Board (LHIB) has been established in shadow form by London Councils, the NHS and the Greater London Authority, anticipating legislation that will give it a statutory basis by April 2014. Its purpose is to provide a London-wide approach on key health concerns to complement work at borough level. There is a proposed top-slice of 3% of the London boroughs' allocation for health improvement from next year and in the meantime PCT Cluster CEOs have agreed to release £2 million for this year.

The Board is made up of the Mayor and his adviser on health, four senior borough representatives, NHS London (including its Director of Public Health) and representation from GPs in London and academic health sciences. It has met three times and in the latter half of 2011 developed four workstreams for its initial focus – tackling alcohol abuse and childhood obesity, cancer prevention and early diagnosis, and information transparency. The aim was to set up some projects rapidly and see how much impact could be gained so that the boroughs would be encouraged by their investment, and partnership working would become well embedded. Each workstream has a borough chief executive lead and project teams include directors of public health, adult social services and children's services with other local authority and NHS officers and some voluntary sector representatives.

New priorities will be developed before long, with a view to developing clearer criteria based on borough level plans and data. Helen hopes that over time the boroughs will want to collaborate more to achieve pan-London outcomes on areas such as air quality. Helen's current team is also the GLA health team and provides the secretariat for the LHIB itself.

Helen was asked why there was no third sector representation on the LHIB. In answering she also noted that the Board does not meet in public. This will be reviewed but as HWBs have VCS representation, it is hoped that the sector's perspective is sufficiently included.

Laurie noted that some HWBs were themselves small with limited external representation though in those cases there were normally sub-committees with broader membership. Some HWBs are large but inclusive, and there remain questions about which is the most functional model. Kieron noted that Lambeth HWB's composition is: six councillors (from all parties), six officers and two community representatives. There is a commitment to continuous community engagement for co-production of services. This is embedded in the HWB's principles and all proposals will be challenged and monitored to push the system to fulfil the principles. Meetings take place in public, open to questions from the public and using a variety of venues.

Many local authorities have adopted the Marmot principles as their policy.

There was a question about whether there are quality of life indicators that are common to all HWBs. The concern is that given the amount of change going on there could be some key issues simply vanishing from agendas. Helen noted that there are 66 indicators offered by the Department of Health against which boroughs have to report, though there will not be expectations of reports to the DH on performance in these. The London Health Observatory is finding data sets to inform HWBs on the indicators. (It is supporting 40 of them at this stage.) While 66 sounds a daunting number, it is a shorter list than previous measures and crucially includes public health determinants.

In further discussion, it was noted that many local authorities have adopted the Marmot principles as their policy.

The differences in style and approach of local authority and health service commissioning caused further lively debate with claims for each of them that they used tougher procurement rules and were therefore less user-friendly for the VCS. Kieron's experience was that local authority commissioners are more geared up to assisting voluntary organisations through the process, and he also noted the greater likelihood of their building in social value criteria to the decision-making process. It is certainly the case that changes in health service structures have meant, in some parts of London, far fewer contracts going to the VCS as budgets have been cut or reorganised. It is undeniable that health service commissioning practice has developed around very large contracts – Helen in particular believes that the move to local government will assist in creating better practice in relation to public health commissioning.

The speakers were asked about the use of hubs (i.e. building-based services) for health improvement work. Kieron explained that these can be seen as of limited value, being hard to locate effectively to serve a broad population and hard to sustain high levels of use over a long period. Lambeth is among the boroughs looking at making use of existing facilities to reach different targets, e.g. schools or pharmacies. They also know that such services will be most successful where they are based in community-run facilities. Helen noted that the LHIB is experimenting with "talk cancer" pop-up shops and that other services are looking at sharing these for different purposes. Laurie quoted the successful experience of Kent County Council's public health department in using shops located in shopping centres to reach young people on health issues, combining services such as chlamydia screening with games to encourage young people over the threshold.

Discussion returned to concerns about the risk of short-termism in decision-making by local government (i.e. fitting between elections) compared with the long horizons needed for health improvement. Those speaking for local government believe that there is some scope for work that is not tied to the political cycle but looks to change over 15 or 20 years. Officers need to argue for the right to retain some portion of the budget for this longer tem work. Helen confirmed that she sees attitudinal change amongst elected members, e.g. recognition that the real outcomes of programmes to cut childhood obesity or smoking cannot be seen in less than 20 years.

Among the major benefits of locating public health in local government is the ability to integrate health improvement into all parts of the council, linking it into housing and children's services, for example. Helen commented that when she worked on this area in Westminster she saw the whole borough budget as hers, "to be infected with public health aims".

The Local Government Information Unit is looking at the future of social care and has identified a funding gap of 9%. The biggest implication of their work, however, is that a high proportion of public health funding needs to be spent on work with older people – this would require a political and attitudinal shift in borough thinking. The political decisions need to be about the balance between treating ill-health, improving health, and maintaining better health. This involves choices about short term and long term work but also raises questions about where effective action can take place – e.g. how far employers can be encouraged to create an improved working environment to foster a healthier workforce (with measurable "bottom-line" outcomes for the company). Not all public health spending, that is, needs to be done by public health professionals.

The balance between treating ill-health, improving health, and maintaining better health

With thanks to LGIU for providing excellent meeting facilities