

# HEALTHY DIALOGUES

EMBEDDING HEALTH  
IN LOCAL GOVERNMENT

Dr Claire Mansfield



\* *Cover illustration by Jenna Collins*

New Local Government Network (NLGN) is an independent think tank that seeks to transform public services, revitalise local political leadership and empower local communities. NLGN is publishing this report as part of its programme of research and innovative policy projects, which we hope will be of use to policy makers and practitioners. The views expressed are however those of the authors and not necessarily those of NLGN.

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Any mistakes or omissions are, of course, my own.

**Dr Claire Mansfield**

**NEW LOCAL GOVERNMENT NETWORK**

# FOREWORD

**The return of public health to councils is one of the major devolutions of power to local government. Alongside the government's health reform agenda, it presents a huge opportunity for councils to improve the health and wellbeing of our local populations.**

With the establishment of Health & Wellbeing Boards, the development of integrated health and social care and the co-ordination with wider services like housing and transport, local councils now have a critical role in delivering better healthcare for all.

In Kent, specifically on public health, we are working with health partners to reduce mortality for people with diseases such as cancer and cardiovascular disease. We want to create the conditions where people are able to take ownership and responsibility for their health.

For example, we know that with the right treatments and targeted interventions – some of which are relatively cheap and simple – we can reduce the number of deaths from cardiovascular disease, and that if people understand the symptoms of major diseases such as cancer they can get access to treatment and support earlier. However, for these treatments and interventions to work practitioners must ensure that patients can access services, and are getting the right advice and information.

Although our process of transferring public health to the council has not been without its challenges – embedding these new structures in a two-tier area is particularly complex – the team is embedded and relationships are strengthening. But like many councils, we recognise that there is much more to do. The first year is understanding what we have inherited from the NHS and how the money is spent. Next year will be time to challenge and innovate. This NLGN report highlights the challenges that councils and partners have faced in transferring public health and gives a useful sense of the current landscape. It also highlights some broad recommendations for the future and suggests issues that still need to be overcome.

The future of public health must focus on the wider determinants of health and wellbeing. We need to ensure that we are delivering services which tackle problems early to prevent poor health, encourage more individual responsibility and manage rising demand within the system. The real prize will be fully aligning our public health priorities to public health spend, which means re-thinking some of the existing contracts that were carried over to us from the NHS.

In doing this, we must recognise that tackling the wider determinants of health in many cases is a long game. We need to take a long term strategic view of outcomes – but some significant early gains are there to be taken. I look forward to working with the sector to develop new and innovative ways to make the transfer of public health work and to deliver integrated and better healthcare for all.

**Cllr Paul Carter**

**LEADER, KENT COUNTY COUNCIL**

# 1 INTRODUCTION

**In April, local government regained its responsibility for public health. For the first time in a generation, councils now have direct responsibility for co-ordinating action to prevent illness and to improve the health of their communities. These changes have placed local authorities in a pivotal position where they can integrate public health with council services such as housing, planning and transport, and co-ordinate spending decisions on ‘traditional’ health promotion and health protection measures with action on the wider determinants of health.**

Better than expected public health spending allocations have gone some way to allaying the concerns of local government and others. However, the possibilities presented by the new system go far beyond simply reconfiguring the deployment of the specific budget. The prize is not the specific public health budget, but the totality of health service and council spending in an area. As one council leader put it, ‘with the public health portfolio, we now have the full armoury to deliver our vision for our community’s future’.

While there are many benefits of placing the public health portfolio within local authorities, there are challenges and difficulties that have been, and will need to be, overcome before public health will be truly embedded within local government. This research has engaged (through a survey, interviews and case studies) with public health teams, senior officers, members and community stakeholders in order to look at the public health transfer from a wide range of perspectives. The report gives an overview of how the transition has gone so far and notes specific challenges and opportunities that have been identified.

This report is organised into three sections. The first section looks at the challenges, difficulties and solutions that public health teams have experienced during, and since, the transfer. The next section examines the extent to which public health has been integrated into local government and the final section examines if the transfer and integration has had an impact on public health priorities and spending.

## 1.1 KEY FINDINGS

- The logistical transfer of the public health teams is generally considered a success. There are still issues (e.g. access to data) but these problems have been identified and solutions are being worked on. The focus of the work for the past year has been on getting the structure of public health and the Health and Wellbeing Boards (HWB) worked out, but this now needs to translate into action.
- The most difficult part of the transition for public health teams has been adapting to working within a local government culture and their new accountability to members and residents. Directors of Public Health in particular have had to adjust from being a decision maker to being an advisor.
- In general, good attempts have been made to integrate public health with other local government departments. It is through new dialogues and relationships that greater trust will be formed and innovative ideas for public health and local government as a whole will occur. However, we have identified that greater engagement with community stakeholders and residents will be needed if public health is to be embedded and sustained within the community.
- Public health priorities are changing and are beginning to encompass the wider determinants of public health. However, we found that there is a disparity between the new priorities in areas and the spend. This is, in part, because many of the public health contracts have been carried over from the NHS. It could take over 2 years for members and officers to see the new public health priorities realised until old contracts are finished and reviewed.

The report includes a set of key strategic recommendations for councils to reflect on when considering the public health transfer, priorities and future. These include:

- Strong leadership to create horizontal networks
- Creating space for councils to innovate
- Co-design of services within the community
- Continuous evolution of relationships, contracts and services

The past year has been spent setting solid structures and strategies for public health teams to work within local government – the next year needs to focus on actioning these strategies.



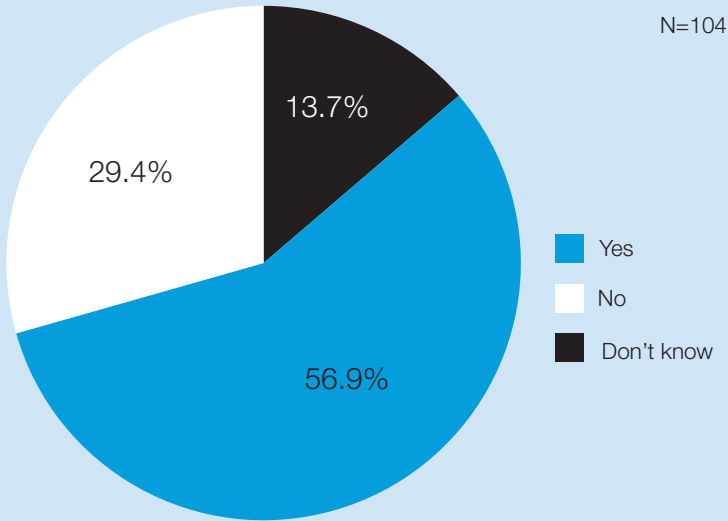
## 2 CHALLENGES IN TRANSITION

**The public health portfolio has returned to what many regard as its first home – within local authorities. To many, the logical place for public health teams to be situated is within local authorities where they can work with other council departments to understand and act on the wider determinants of public health. However, despite the clear benefits of public health being situated within local authorities, the massive undertaking of moving an entire department from the NHS to local government cannot be underestimated.**

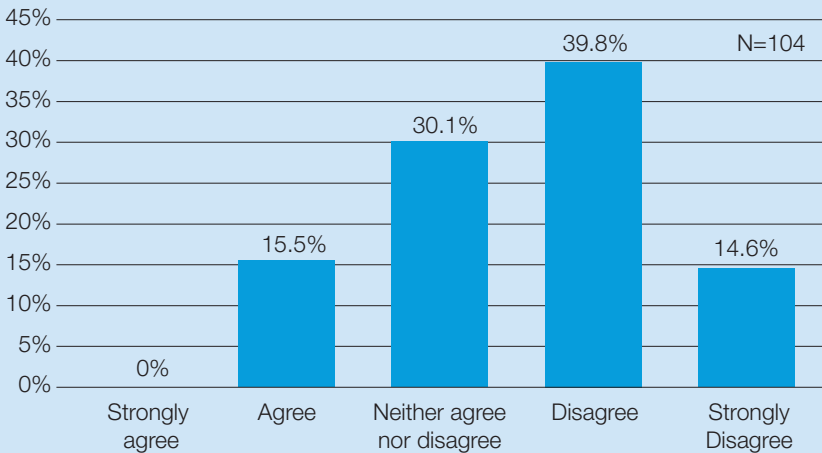
This section will examine how well the public health transfer has gone so far. It will detail the particular challenges and difficulties that public health teams have experienced from navigating the structural challenges of two-tier authorities to the cultural change of moving from the NHS to local government.

On the whole, our research found that both local authorities and public health teams are very positive about public health moving to local government. However, as Figure 1 on the following page notes, nearly 56.9 per cent of people surveyed did feel that there had been challenges in bringing together the local government and health sectors. Similarly, Figure 2 shows that nearly 55 per cent of survey respondents felt that the organisational change from the NHS had not been easy.

**FIGURE 1** Have there been any challenges in bringing together the local government and health sectors?



**FIGURE 2** The organisational change from the NHS to local authorities has been easy.



However, a large proportion of those that responded also felt that many potential challenges had been identified early and thus had minimal impact. Survey respondents noted that:

*The challenges have been numerous and ongoing. The key is developing an understanding between different players about the ways different organisations work, identifying common agendas and seeking opportunities for alignment and added value, developing mechanisms to assist in that process.*

*There was considerable work by the Director of Public Health, his staff and the Shadow Health and Wellbeing Board to develop good relationships prior to the changes in April 2013.*

In general, we found that most of the challenges identified could be categorised into two themes:

- **Structural challenges:** the logistics of moving the public health teams into local authorities and where they should fit within the local authority structure.
- **Cultural challenges:** the adjustments that the public health teams need to make when moving from one institution to another.

## 2.1 STRUCTURE OF PUBLIC HEALTH WITHIN LOCAL GOVERNMENT

When public health teams moved to local government one of the most immediate issues that local authorities needed to deal with was where the public health team would fit into the current structure. This was a decision that was taken individually by councils according to local needs and current local authority structures. Many different models are being used and public health teams can be found in departments as diverse as Adult Social Services to Regeneration, Economic Development and Environment. However, from our research, the most common place for Directors of Public Health to sit is within the Chief Executive's Office. For many authorities that we spoke to, this is important as they hoped it would ensure that public health is seen as an important issue and, knowledge and skills related to it, would not get lost in the local authority.

In some cases public health teams have moved from the NHS as one whole team and into a department of their own. In other areas, members of the public health team have been scattered throughout the organisation. For example, in one council we spoke to the Director of Public Health and three public health leads sit within the Chief Executive's Office, some members of the team are situated within the Commissioning Unit, some within Strategy, Performance and Policy, and others were sitting and working with Children's Services. Interestingly, each council that we spoke to couldn't envisage the transition happening in any other way and felt that the other model would not have suited their council. Clearly, both models have their advantages.

- Teams that moved over as a distinct unit, felt less isolated and better able to provide support for other team members. Their work routine and ways of working required less adjustment as these were directly moved over from the PCT.
- Teams that had been distributed throughout the authority felt that with a greater level of integration there was a greater knowledge exchange between the public health team and the rest of the authority.

However, one problem that has arisen when public health teams were spread out throughout the local authority is the burgeoning issue of different pay structures within the transferred NHS system and the local authority. During our research we were given examples of local authority officers, who were line-managers of former NHS public health staff, and were being paid less than those they managed. This situation is unsustainable and will undoubtedly lead to ill feeling between the public health teams and local authority officers. One particular officer we spoke to noted that there had been 'unease' about this, and over time this unease will only grow because if the public health team is viewed as having a luxurious ring fenced budget and pay scale, divisions will be created amongst the teams that should be working together to embed health. Conversely, however, in areas where NHS pay scales are not being used, local authorities are reporting that recruitment for public health roles is very difficult. Clearly, if other local authorities and Public Health England have not changed their levels of pay, public health practitioners will be more inclined to work within the organisations that offer higher salaries.

## CASE STUDY: SURREY COUNTY COUNCIL

Surrey County Council have situated their public health team strategically in the Chief Executive's Office in order to be able to influence the whole council. The public health team in Surrey moved over from the NHS to the council in April 2012 so that there could be a shadow period to aid a smooth transition. As other councils have found, it was difficult to make the plan real until the team were actually within the council's structure and using council systems and policies.

The public health team (nearly 60 posts) initially moved over to the local authority as a standalone team still using NHS systems and policies. They found that it was difficult to integrate and embed with other departments within the council whilst still being NHS staff. In light of this, the council made the decision in April 2013 to place the public health team within the Chief Executive's Office, working alongside members of Surrey County Council's Policy and Performance, Legal and Democratic Services, Communications and Cultural Services teams. This has led to an improvement in how the team has embedded and it has also been easier to work across the authority. However the early move in 2012 helped former NHS staff to understand the wider local government context.

It is recognised that there is more to do in Surrey around joint commissioning although this has improved since the transition through the building of strong relationships and joint working in the Health and Wellbeing Board. The Health and Wellbeing Board spent a full year in shadow form working together to increase levels of trust and understanding and agreeing priorities.

### 2.1.1 TWO-TIER AUTHORITIES

Organising public health within two-tier authorities is a complex process. While public health teams in unitary authorities need to create links between all authority departments and also work with other partners such as the CCGs, public health teams located in two-tier authorities have another dimension again - ensuring that they work with district councils. This has

been a particular challenge and some districts have reported serious issues with the transfer of the public health portfolio. For example, one authority reported that they felt they had more influence over public health outcomes when public health was within the PCT than after the transition to local government. In addition to this, one survey respondent noted that public health teams had a 'lack of understanding of the role of district councils', with another noting that:

*Health see their relationship with the unitary level not the district level. The positioning of public health in upper tier authorities was not done with districts and boroughs in mind.*

As a result, engagement of districts and boroughs into the new public health agenda remains a challenge. This is a concern. District councils are particularly important for public health. As the authorities responsible for planning, leisure, housing and environmental licensing, their cooperation is essential in creating better public health for residents. Some councils have worked particularly hard to create links and relationships between members and officers from the district councils and the public health team.

Leicestershire County Council's public health team has a successful working relationship with the district councils. Through a combination of well thought out structures and strong leadership, Leicestershire has created successful relationships between the districts, public health team and wider council departments.

## CASE STUDY: LEICESTERSHIRE COUNTY COUNCIL

Leicestershire County Council's public health team moved over to the council more than two years ago. Leicestershire's Chief Executive wanted the team to have a high profile within the council and so they were allocated their own department within the authority. The Director of Public Health reports to the Chief Executive and sits on the Corporate Management Team.

There are seven districts within Leicestershire and each one feeds into the Health and Wellbeing Strategy. Each district has a 'Staying Healthy

Forum' – a health and wellbeing forum that includes a member of the public health team and members and officers of both the local authority and other stakeholder organisations. Each forum sets their own district's priorities.

The districts have always had a good relationship with the public health team and before the recent changes, a member of the PCT would visit each district. This relationship has continued and a member of the public health team spends one day a week working within their assigned district.

Two members from the district leaders group sit on the county Health and Wellbeing Board.

There is a great acknowledgment within Leicestershire that some things are done better locally, and there is a realisation and acceptance that both tiers may depend on one another in certain circumstances; the districts need the county to carry out work that they want to do whilst the county needs the districts to push through work that they want to do. For example, districts are responsible for housing and, as housing can often be a wider determinant of public health, it is important that public health teams work with the districts to ensure that all residents are in suitable homes.

Each district has a Health Improvement Officer (some full-time, others part-time) that meet regularly with each other and also meet with the relevant NHS and public health teams. The districts and the Health Improvement Officer that we interviewed felt they had been fully engaged in the public health transfer.

One of the most important schemes that they have in Leicestershire is a community grants system from the public health fund. These grants are only in the single thousands of pounds but are a recognition of the important role that the districts play in promoting public health. They also develop trust between the public health teams and the district councils. North West Leicestershire Borough Council have trialled a very successful smoking cessation campaign through one of these grants, and it could now be rolled out across the county.

The key to the successes apparent in Leicestershire is the leadership shown by members. Leicestershire County Council has built very solid structures to manage the relationships between all interested parties. However, the informal rapport that has been built is just as important. The chairman of Leicestershire's Health and Wellbeing Board, meets District Health leads on a regular basis to discuss both local issues that have arisen and brief district colleagues on progress on Health and Wellbeing issues across the County. The new structures have created new relationships but it is equally vital to develop these relationships with regular face to face meetings, as it is within these informal discussions that trust is built up and innovation can begin.

The chairman of Leicestershire's Health and Wellbeing Board has also developed a good relationship with the Director of Public Health and is conscious of the cultural changes that the public health teams have had to make. He has made small changes to accommodate these changes in culture. For example, noting that health sector professionals often find the 'talking shop' nature of council meetings a little arduous, he has consciously tried to make sure that meetings do not go on beyond two hours.

## 2.2 COUNCIL CULTURE

As well as structural changes there have also been many cultural changes that have had an impact on the transfer of public health. Navigating the council has been a challenge for public health teams, both in terms of 'getting the job done' and understanding the new system, but also the human and emotional impact on people who had worked for the NHS (sometimes for over 20 years) now moving to a completely different organisation. Public health teams have had to get used to a completely different dynamic within local government.

First and foremost, public health teams have had to adapt to being accountable to members. The NHS is traditionally accountable to central government, but following the transition, public health teams are now accountable to the electorate and specifically their local authority members.



**FIGURE 3** The health sector has found it difficult to adapt to greater accountability with local authorities

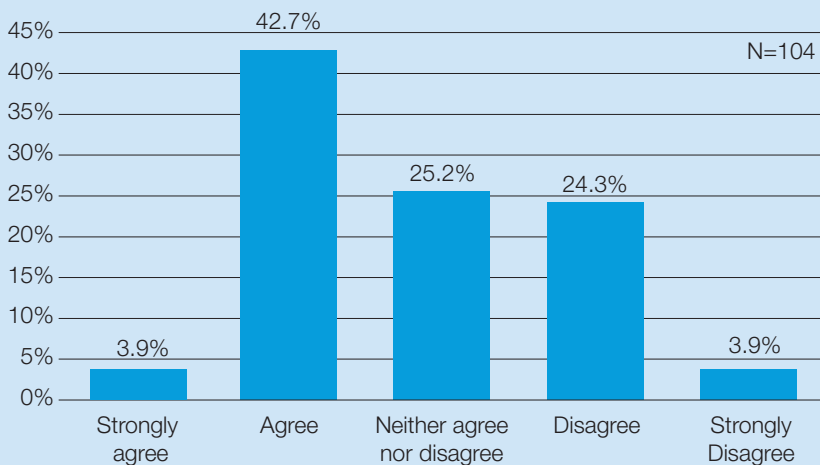


Figure 3 demonstrates how difficult many public health teams have found this changing accountability. A public health team member noted that their team are 'still getting to grips with the way things are done round here' and that 'the political dynamic of local government is the most difficult'. Nearly half of those surveyed noted that the health sector had found it difficult to adapt. Breaking this down further, we found that 62 per cent of senior officers and 37 per cent of DPHs that responded to the survey felt that the health sector has found it difficult to adapt to greater accountability with local authorities. This indicates that those already working within local government felt that it was more of an issue than those within the public health team. One respondent made a particular comment on the accountability that the public health team now has to elected representatives, remarking that:

*Different organisations have different procedures, processes and approaches... Teams who previously worked for the NHS have had to adapt to local authority ways of working, including acknowledgement of differences when working for a political organisation, where decisions are ultimately made by elected members.*

Another respondent noted that:

*Understanding organisational cultures across both sectors has been the greatest challenge. The scrutiny functions of the Council are sometimes confused with the strategic functions of the Board.*

In some instances, these cultural differences have required public health teams to change the way they carry out their role. One DPH described their changing role clearly when they noted that they were now an advisor and not a decision maker. While another DPH noted that:

*Members make decisions. We provide them with professional advice.*

Despite this changing accountability, we did not hear any reports of serious issue between members and public health teams. Both members and DPHs noted that it took time to adjust but they also noted that not all challenges had been bad. In particular one DPH noted that the public health team has changed the way it writes white papers – they are now a lot more straightforward and concise. In some instances members had challenged the public health team ‘to go further’. In particular, members provided invaluable qualitative evidence of the issues in an area that can add to and develop the traditional quantitative evidence used by public health teams.

Public health teams have also had to adjust how they communicate their public message. This has been difficult as many public health teams view communication as a particular skill of their role. However, one senior officer from a local authority described a difficulty when the public health team organised a comedy night to discuss a particular public health issue. The communications department felt that, in times of financial constraint, the local authority should not be seen to be spending money on ‘frivolous’ comedy nights. The public health team found this difficult as they wanted to get their message out with the greatest impact possible, but within politics and local authorities they are many other considerations that need to be taken into account.

Other stakeholders have also noted the difficulty in adapting to the culture and dialogue of local authority workings. One Healthwatch representative felt that it was a pity that the Health and Wellbeing Boards had been set

up through the council structure as consequently it was quite adversarial. She felt that the language and behaviour within the meetings 'would be considered unprofessional in other workplaces'. That is not to say that the behaviour was different from many council meetings throughout the council, or indeed the jeering within the House of Commons, but it was not something that those from outside council life were used to. As noted earlier, the Chair of Leicestershire County Council's Health and Wellbeing Board is very conscious of this and has also demonstrated good leadership by ensuring that meetings are short, succinct and to the point. In both of our case study areas, Leicestershire County Council and Sunderland City Council, strong leadership from a number of individuals has been the key to overcoming the cultural challenges and creating a successful public health transition.

Where the transition has gone particularly well, this has tended to be because the Director of Public Health has been a strong leader and often a forceful character. One member noted that:

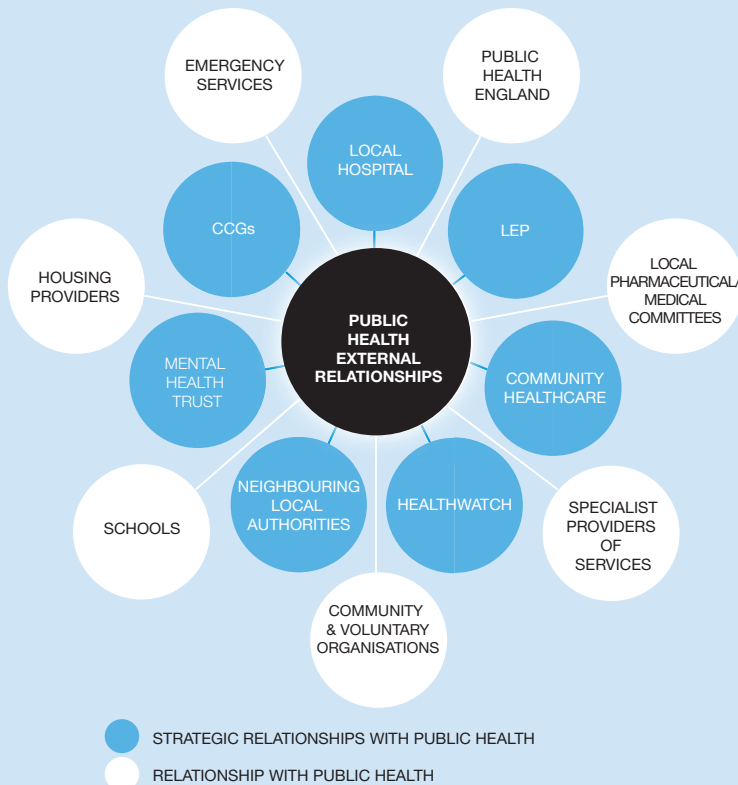
*It is important for the Director of Public Health (DPH) to have the personality to work with members and officers. Often they are first and foremost clinicians and find it difficult to manage a committee.*

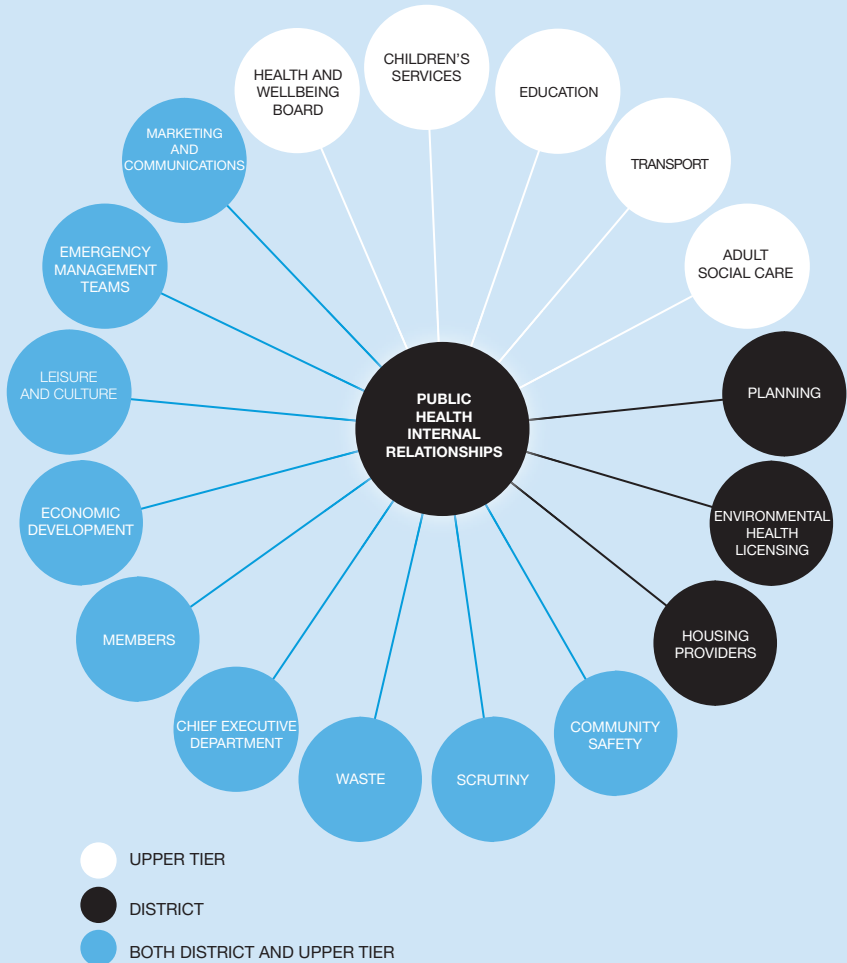
If conversations and trusting relationships are to be built and succeed, those leading the public health agenda need to demonstrate strong leadership skills to increase and cement networks horizontally across the council.

## PUBLIC HEALTH EXTERNAL AND INTERNAL RELATIONSHIPS

If public health is to be embedded within local government and the wider community, relationships and conversations that reflect the wider determinants of public health must be ongoing. These two diagrams represent the possible internal and external organisations and departments that public health teams will need to create and maintain relationships with. Whilst not all relationships may be relevant to every locality, these diagrams can act as a checklist for authorities to make sure all organisations and departments have been considered.

**FIGURE 4** Public health external relationships



**FIGURE 5** Public health internal relationships

## 3 EMBEDDING PUBLIC HEALTH

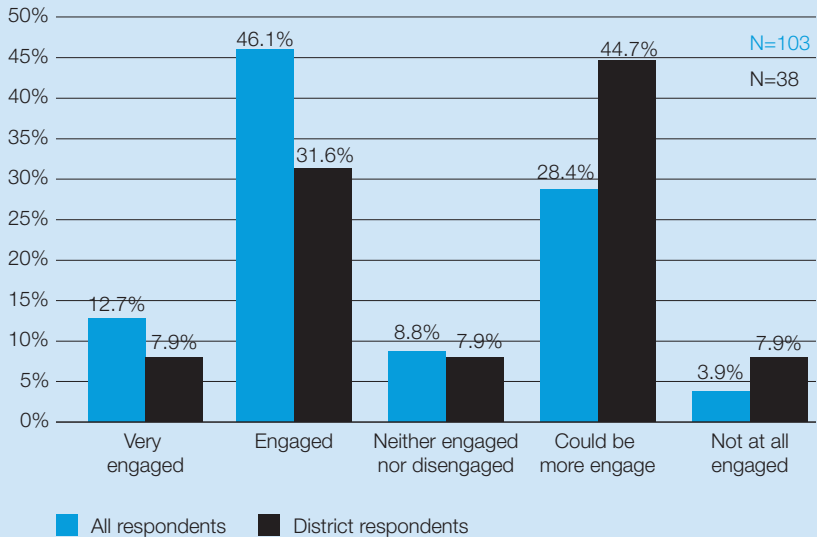
While the previous section focused on how the public health transfer is progressing, the success of this transition will, in many respects be dependent on how embedded public health has become, and can be, within a local authority. The new public health portfolio opens up many doors for local authorities and gives them opportunities to look after their residents in a whole new way. However, this will only be possible if public health is well integrated within the local authority and if other departments are aware of the plethora of possibilities and advantages of working with the public health teams.

This section will look at the extent to which local authorities (officers and members) have engaged with the public health portfolio, what mechanisms have been put in place to encourage integration, and how far public health is engaging with wider stakeholders.

### 3.1 ENGAGING THE LOCAL AUTHORITY

As can be seen from Figure 6, 59 per cent of those surveyed felt that local authority departments have engaged with and influenced the public health portfolio. As the public health portfolio is so new to local authorities this should be taken as an encouraging result. However, a not insignificant percentage (28.4 per cent) of those surveyed felt that other departments could be more engaged. When we broke this figure down further, it was shown that it was councils in particular that felt other local authority departments could be more involved. Nearly 53 per cent of survey respondents from district councils felt that other departments were not at all engaged, compared with 40 per cent who felt they were engaged. As noted in the previous section, it is concerning that district councils do not feel other local authority departments have engaged with public health, as it is through other departments and stakeholders that the wider determinants of public health will be dealt with.

**FIGURE 6** To what extent do you feel local authority departments have engaged with and influenced the public health portfolio?



Interestingly, only 5.2 per cent of Directors of Public Health felt that other local authority departments could be more engaged, compared with 30.5 per cent of Senior Officers, 40 per cent of Heads of Service and 50 per cent of Community Stakeholders. It is those that are furthest away from the Public Health Department that feel that other local authority departments could be more engaged, whereas those working directly within the public health teams are more confident of the engagement from other local authority departments.

Interviews also confirmed this, with a number of Heads of Department noting that 'how aware the rest of the local authority departments are, depends on which department and how senior they are' and also that 'knowledge of the public health portfolio probably depends on where you sit within the council'. These results show that whilst public health teams may feel that they are fully engaged with other council departments, those in the other departments feel that they could be more engaged with the public health

portfolio. It is clear from these results that the further away from public health that someone works (either within the districts or other council departments), the less confident they are that they are fully engaged with the public health portfolio. For public health to be truly embedded within local government, all departments and districts need to feel that they have a role to play in the public's health.

Some departments, particularly those that already had existing relationships with the public health team, continue to feel more engaged with public health. For example in one council that we spoke to, the Community Services Department have had a relationship with public health since 2008. They were initially funded by the PCT to run some programmes for six months as they both realised they were trying to reach the same people. Because of this, previous relationship with public health, it has been easier for Community Services to forge and strengthen this relationship as they already knew the team members. They were approaching it from a 'standing start' unlike other departments. In addition, in areas where the public health teams have been distributed throughout the authority, the public health message has been spread faster as the public health teams will have a physical presence in a number of departments. However, it remains to be seen if public health will lose some of its impact by not being a solid, defined team.

### 3.1.1 MECHANISMS OF ENGAGEMENT

Throughout our research we uncovered a number of different methods and mechanisms that have been used to engage and inform the members and officers of the local authorities with the public health portfolio. These have included:

- **Training**
  - Many authorities have carried out seminars and development workshops for members, officers and the new public health team. One member noted that before these sessions he just didn't know how many residents smoked in his area and was also particularly surprised by the number of instances of mental health episodes amongst children in his area. He now could not imagine trying to carry out his work without knowing these statistics.



### ■ Information Sharing and Conversations

- An internal magazine, included with every staff members' payslips that profiles the public health team.
- Sunderland have condensed their Health and Wellbeing Strategy on to one page. The public health teams 'Plan on a Page' was then disseminated to all departments within the local authority and senior officers can easily identify how their work can fit together with Sunderland's Health and Wellbeing Strategy.
- One authority ran an 'information fair' for the public health team. Each department had a stand with information about what work their department was carrying out. Not only did this help inform the public health teams, but it also gave a face to many names and increases the chances of further 'water cooler' discussions.

### ■ Evidence discussions

- The Director of Public Health's annual report is now discussed by councils. This has been particularly effective as previously this had not been a document that members would have necessarily seen. The report is now discussed at council level and gets full press coverage.
- In one local authority area they programme discussions on issues such as mental health, domestic violence and housing every two months. One senior officer prepares and presents the evidence and problems and senior officers from across the authority discuss these, how it could impact on their department and how all departments could work together to address the issue.

## 3.2 WIDER STAKEHOLDER AND PUBLIC ENGAGEMENT

The public health transition to local authorities provides an excellent opportunity for public health teams to engage with the public and wider stakeholders. Local authorities have already established lines of communication with residents and relationships with wider stakeholders

such as community and voluntary organisations. For public health to be truly integrated throughout local authorities, teams will need to engage with wider stakeholders to have a clearer view of public health requirements and the most appropriate methods of intervention. If public health is to move from treatment to prevention, and individuals are to have more responsibility for their health, it is essential that councils engage with local communities. This is necessary, not only to reflect the current needs of local communities but also to gain the cooperation of local community groups. It is through community ownership of public health campaigns that the public health message will move forward.

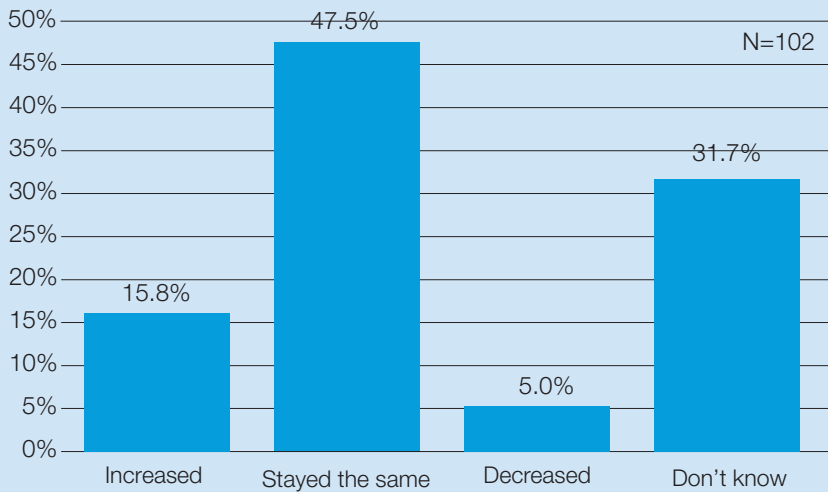
Local authorities have a wide spectrum of connections to community groups from 'friends' of local parks to carers' networks. However, so far, engagement with wider stakeholders in creating the Health and Wellbeing Strategy and creating action plans to address the health needs of the population, appear to be lacking. The strategy and action plans must be determined in conjunction with the public and wider stakeholders if they are to be embraced by, and sustained within, the community.

Our research revealed that over 50 per cent of those that responded to the survey had not consulted with the public on any health issues so far. As noted, a clear advantage of the public health portfolio's transfer to local authorities is the relationship that local government have with their residents. Local authorities are used to public consultation, and can provide invaluable qualitative and anecdotal evidence that gives a different perspective of what is happening in an area. Figure 7, as with research from our publication *Healthy Places*<sup>1</sup> last year, suggests that public consultation is not and has not been a priority for public health teams during their transfer to local authorities.

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<sup>1</sup> Kuznetsova, D., (2012), 'Healthy places: councils leading on public health', NLGN, UK.

**FIGURE 7** Has the amount of public consultation, with regard to public health, increased, stayed the same or decreased since public health moved to local government?



In general public consultation has stayed the same, despite local authorities perhaps being better placed to consult with the public. 5 per cent of those that responded to the survey felt that public consultation had decreased. This was a view especially expressed by respondents from the districts that felt that their upper tier authority had a very set agenda for their public health portfolio and did not want to consult either with the public or their districts. However, as noted in *Healthy Places*.

*The return of public health to local authorities and the development of Health and Wellbeing Boards brings a new imperative for health services to be accountable to local communities. Through this new democratic mandate over health, local authorities will be able to enable citizens to become active co-producers of health outcomes (Kuznetsova, 2012: 61).*

As a consequence of our research it was suggested that the public and

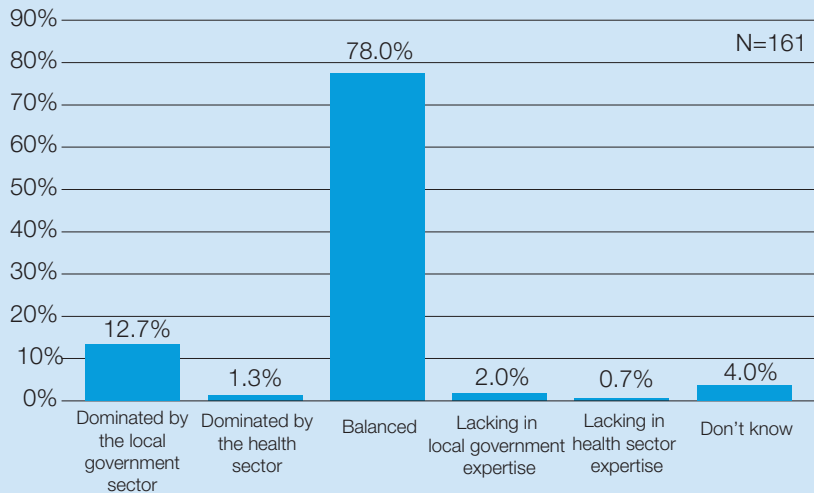
stakeholders should not just be consulted about local health and wellbeing issues but services should in fact be co-designed with residents and stakeholders. It is recommended that this be done at the most local level possible (i.e. CCG locality forums, district forums) and that the public health budget should be distributed through these locality groups. Co-designing services in this manner would not only ensure that local groups are engaged with the public health portfolio, but also guarantee that needs are addressed on a very local level. Authorities can vary enormously even from street to street, and co-design would ensure that specific needs and barriers to good public health are addressed.

### 3.2.1 HEALTH AND WELLBEING BOARDS

Health and Wellbeing Boards are a good reflection of the health and wellbeing engagement in an area. As an example, we looked at the membership of health and wellbeing boards to examine whether people felt the membership was balanced between local government and the health sector. Health and Wellbeing Boards demonstrate the focused nature of health and wellbeing thus far.

Figure 8 demonstrates our survey respondents' views on the balance of the membership of the Health and Wellbeing Boards. Clearly the majority of people (78 per cent) felt that the Health and Wellbeing Boards in their area are balanced. However, a not insignificant number of people (14 per cent) felt that the Health and Wellbeing Boards are dominated by the local government sector. Breaking the analysis down further, a higher percentage of respondents from district authorities (22 per cent) felt that the Health and Wellbeing Boards were dominated by local government. Similarly, 23 per cent of Heads of Service and 20 per cent of community stakeholders felt that the HWB Boards are dominated by the local government sector. In comparison only 8.7 per cent of Directors of Public Health felt that the HWB Board is dominated by the local government sector. Perhaps unsurprisingly those who are more closely connected to the HWB Boards feel that they are more balanced. These results concur with our earlier findings (Figure 6) that those working closely with public health are more positive about the transition so far.

**FIGURE 8** How would you describe the health and composition of the Health and Wellbeing Board in your area.



One district chief executive noted the level to which they felt the upper tier of local government dominated the Health and Wellbeing Board in their area:

*The Board has been significantly changed since its successful shadow form and is now 'stacked with 3 county council Executive Councillors, 3 county council Directors and a further 5 county councillors. The 7 District Councils have lobbied to no avail for greater DC representation.*

Others have also commented on the lack of representation from the voluntary sector:

*There is no voluntary sector representation. This is clearly within the letter of the legislation, but not the spirit of it and shows a lack of awareness of the major contribution made by District Councils, voluntary organisations, etc... Fair to say, we are not happy!*

One member of a Health and Wellbeing Boards that we spoke to noted that:

*A lot of time has been spent on refining the structure of the Health and Wellbeing Board but we need to make sure that integration is not the end point.*

The past year has been spent on setting solid structures and strategies for health and wellbeing – the next year needs to focus on action and engagement. As noted previously, if the wider stakeholders (including districts and community and voluntary organisations) are not in some way involved in all steps of the process, it will be much harder, if not impossible, to embed the public health and wellbeing agenda within the community.

## **CASE STUDY: LONDON BOROUGH OF HOUNSLOW – ENGAGING THE COMMUNITY**

The public health team in Hounslow has concentrated on integrating with other council departments and engaging community stakeholders. Hounslow is a diverse community with many different socio-economic groups and consequently, its public health needs are also varied.

The Public Health team in Hounslow is combined with the Preventive Health and Wellbeing team to form the Health and Wellbeing Unit. This unit is located in the Regeneration, Economic Development and Environment (REDe) directorate, within the Housing, Leisure and Public Health department. The advantage of being located within REDe, rather than having a separate Public Health directorate, is that the team 'have more of an opportunity to impact on the wider determinants of health, such as Housing, Community Safety and Business Regulation'. For example, they are jointly commissioning a new Rough Sleepers Outreach service, which will include a nursing resource to address health needs, in partnership with Housing and Supporting Independence Service teams in REDe. Their aim is to reduce the current number of homeless in the borough, prevent future residents from becoming homeless, and to tackle health inequalities faced by this group.

In addition, Hounslow have engaged widely with community stakeholders when selecting representatives to sit on their Health and

Wellbeing Board. While some councils have a narrow and focused Health and Wellbeing Board membership, Hounslow have made a deliberate effort to engage with wider stakeholders.

Below is a list of some of the institutions and stakeholders represented on the Hounslow Health and Wellbeing Board:

### **VOTING MEMBERS**

- Healthwatch
- Co-optee – VCS representative for disability
- Carers representative
- Co-optee Community representative
- Job centre Plus
- The Education Improvement Partnership

### **NON VOTING MEMBERS**

- Local Mental Health Trust
- VCS representative for health and social care
- The Independent provider forum
- Hounslow & Richmond Community healthcare
- Co-optee – Heathland Wellbeing Partnership
- Representatives from the fire and police Services
- Representatives for the local hospitals

# 4 PUBLIC HEALTH PRIORITIES AND SPENDING

One aspect of the public health transfer that was widely anticipated was local government's acquisition of the (ring-fenced) public health budget. Some viewed this budget as a respite for cash stuck councils, however, some from public health quarters feared that the money would be 'squandered' on other local government services with only tenuous links to public health. The final section of this report will look at whether the public health transition and integration into local government has, so far, led to any change to the selected public health priorities and spending decisions.

## 4.1 SELECTING PRIORITIES

As is perhaps to be expected, those we surveyed cited the Joint Strategic Needs Assessment (JSNA) as the key mechanism through which health and wellbeing priorities for their area were selected. JSNAs are the means by which local leaders work together to understand and agree the needs of all local people. In recent years the role of the JSNA has been strengthened, and in general, councils have whole heartedly embraced this process and gone to great lengths to engage the public and other stakeholders in order to discover the precise needs of their areas. In some cases these discussions identified needs that may not have otherwise been recognised to the same extent. For example, in one local authority the data did not adequately recognise the need of their area to identify carers and support them.

JSNAs inform the local Joint Health and Wellbeing Strategy, which sets the priorities for collective action. It is envisaged that the JSNA and joint health and wellbeing strategy can be the foundations upon which health and wellbeing boards exercise their shared leadership across the wider determinants that influence improved health and wellbeing, such as housing and education.



**FIGURE 9** Members and Officers are changing their priorities and practices.

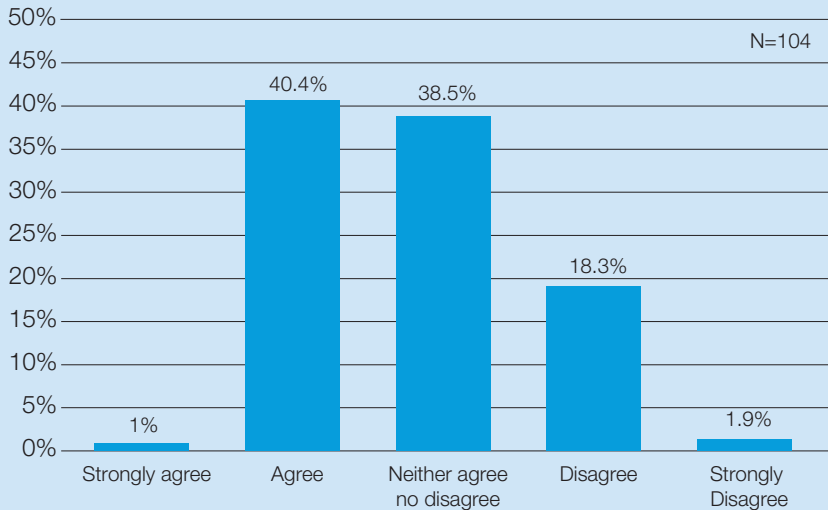


Figure 9 demonstrates that through the JSNA, the preparation of the Health and Wellbeing Strategy and other methods of public health integration, officers and members are changing their priorities. It can also be seen that between 40.4 per cent of those surveyed agreed that members and officers have been changing their priorities and practices since the transfer of the public health portfolio. In particular, some senior officers noted that they were now a lot more aware of what the public health priorities were, and were not. It should be noted however, that practically no one strongly agreed that priorities are changing, which may suggest that priorities are changing slowly. From further research, it appears that new conversations are starting in many areas but that these have yet to be translated into budget decisions or different actions.

There was a similar scenario when we compared the top five public health priorities with the top five public health spends. Informed by the JSNA,

Health and Wellbeing Boards have selected key priorities for their area. In many cases, it seems that the JSNAs, and the processes involved in creating the JSNA, have succeeded in identifying the wider determinants of good public health and feeding these into the Health and Wellbeing Strategies. From the list of top priorities in the table below it can be seen that, as with the practices of members and officers, the health and wellbeing priorities are slowly changing. The ‘health inequalities’ priority that is included in the top five includes a number of key wider determinants of public health such as unemployment and housing. Sunderland City Council in particular has deliberately broad priorities and outcomes in their strategy in order to address the causes of poor health in their area.

	Priorities	Spending
1	Obesity and Cardiovascular Disease (33.9%)	Drugs and Alcohol (57.7%)
2	Drugs and Alcohol (25.7%)	Sexual Health (53.5%)
3	Healthy lifestyles (22.9%)	Smoking Cessation (15.5%)
4	Ageing Population (20.2%)	Healthy Lifestyles (11.3%)
5	Health inequalities (20.2%)	Children/Early Years (9.9%)

One of the most interesting aspects of this table is the disparity between the priorities for local authorities and that which the greatest amount of money is spent on. The primary reason for this is that in most cases, spending budgets were set before priorities. In general, no new services have been commissioned and the budget has been committed to existing contracts. This may change over the coming years as contracts end but for the immediate future there is likely to be a disparity between health and wellbeing priorities and spending. This is likely to cause frustration amongst members as, while they appear to have engaged well with the public health agenda, they will find their new priorities confined by contracts that have already been signed. With this in mind the next section will look at commissioning for public health since the transition to local government.

## CASE STUDY: SUNDERLAND – WIDER DETERMINANTS OF PUBLIC HEALTH

The transfer of the public health portfolio has been used as an opportunity for local authorities to think more broadly about their public health priorities and the outcomes they would like to see for their residents. Sunderland, in particular, has identified, and is addressing, the wider determinants of health and ill health amongst their residents. The health of people in Sunderland is mixed compared with the England average. Deprivation is higher than average and about 13,300 children live in poverty whilst life expectancy for both men and women is lower than the England average (2012).

The public health team and members and officers from Sunderland recognise that in order for campaigns such as smoking cessation and healthy eating to be successful, the wider determinants need to be addressed. For instance if a resident is unemployed they may consequently suffer from mental health issues. If a smoking cessation campaign is to be a success with this resident, it is imperative to address, not only the mental health issues, but the root of these issues, which in this example would be unemployment.

Sunderland aims to create the ‘Best possible health and wellbeing for Sunderland ....by which we mean a city where everyone is as healthy as they can be, people live longer, enjoy a good standard of wellbeing and we see a reduction in health inequalities’<sup>2</sup>. From discussions with Sunderland’s Director of Public Health, Dr Nonnie Crawford, it is clear that the vision for Sunderland includes, not just a greater quantity of life but a greater quality of life for all. It is recognised that it is not enough to solely increase life expectancy: in a city with high levels of deprivation and poverty the quality of life must also be improved. In addition to this, the strategy sets out to ensure that all public health initiatives can be sustained within the community by addressing health inequalities and factors that contribute to these inequalities. The strategy particularly looks at the community and individual

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<sup>2</sup> <http://www.sunderlandpartnership.org.uk/documents/HWBS.pdf>

assets in Sunderland, from social networks to community and voluntary resources to utilising the coast and countryside to provide opportunities for an active lifestyle. This will help to embed public health within the community.

‘Ultimately we want to enable and support individuals, families and communities in Sunderland to enjoy much better health and wellbeing, with less reliance on the public sector in the longer term. This involves recognising and being responsive not only to local needs but also to community strengths and exploring how these can be better harnessed to help address the challenges faced. By building on and utilising the resources and energy of our communities, we can support people to take greater control of their lives to bring about better health and wellbeing outcomes that matter to them, their families and communities.’<sup>3</sup>

The strategy recognises that to see a sustainable improvement in life expectancy for all of the population, including a reduction in inequalities, the wider determinants of health need to be addressed. In order to do this, broader outcomes have been outlined in the strategy. In particular, one objective looks to ‘address the factors that have a wider impact on health – education, housing, employment, environment, and address these proportionately across the social gradient’. This includes six key objectives to reduce health inequalities caused by these determinants. These are:

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Prevent ill health
- Create and develop healthy and sustainable places and communities.

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<sup>3</sup> <http://www.sunderlandpartnership.org.uk/documents/HWBS.pdf>

In order for Sunderland to deliver these outcomes and objectives, they will need to work very closely with other local authority departments, something that is much easier since the public health transition. The strategy aims to set out a solid vision for the future where the entire council will work towards a healthier Sunderland.

## 4.2 COMMISSIONING SERVICES

The focus of the public health transfer so far has been keeping 'business as usual' and this is evident when looking at services that have been commissioned and decommissioned. As noted, in the previous sections most contracts have been transferred over from the NHS. Public health officers noted that services are not significantly different from previous services. For example, third sector organisations that run alcohol treatment centres, still have a contract to do this.

In general, despite priorities changing to incorporate the wider determinants of public health, local authorities haven't commissioned any new services. One public health officer noted that:

*Those organisations that were commissioned by the PCT have been inherited as providers by the authority. We have not yet re-commissioned any of the services.*

The public health transfer has also provided scope for public health teams and other departments to review contracts and identify duplications in services, or services that would be more effective if merged. Potentially this de-duplication of services should not only lead to more streamlined and joined up services but could also lead to significant financial savings for the local authority. However, only 7 per cent of those that responded to our survey indicated that they had decommissioned any services. While this is perhaps to be expected in the first nine months since the public health transfer, this is concerning as many contracts are not expected to run out for three years, which may mean that some of the wider determinant factors of public health will be slow to be tackled.

More positively, councils have begun to review contracts and plan to decommission duplicate services and review services for performance, usage and outcomes, however, this in itself may cause problems with the ring-fenced budget. One officer noted that:

*All existing contracted services are scheduled to be reviewed in the coming year - there is a concern that the savings released may be used to fund budget shortfalls once the ring-fence for public health funds is lifted.*

However, this public health worker was also concerned that services may be decommissioned to fund local government shortfalls in other departments. This worry has been a particular challenge of the public health transfer. One Director of Public Health noted that she had to ‘fiercely protect’ her public health budget. The next section will look more specifically at this issue.

#### 4.2.1 RING-FENCED PUBLIC HEALTH BUDGET

From our research, we found a variety of different perspectives on the ring-fenced public health budgets and these opinions tended to vary depending on how far removed from the public health team the person we spoke to was. In general those that had not been too involved with the public health team either previously or now, viewed the public health budget (and the number of people working within the public health team) as luxurious. It was clear that those not working directly with the public health team are unsure exactly what the budget is needed for and are envious of the ring-fenced budget. This will perhaps improve as public health is embedded further within the local authorities and the remit of the public health department is understood. In contrast, those that have been working with the public health team for a while before the transfer understand the pressures that are on the public health budget.

However, one Director of Public Health reported that:

*People wanting to get their hands on our money is one of the biggest difficulties.*

Another Director of Public Health noted that:

*We have to be clear – many have to fully appreciate that it's not the acquisition of a new budget, it's a new statutory duty. We only want to be paying for things that very clearly have a public health remit. This has caused tensions.*

If public health is to be successfully integrated into local government, these tensions will have to be resolved. Greater information and understanding of each other's duties would clearly help and with more face to face meetings and other official forums of engagement, this should happen over time. Public health officers need to become less protective of their budgets and recognise that often they may get 'better value for money' by linking with other departments. On the other hand, local government needs to create space and funding for all departments to create innovative ideas to tackle the wider determinants of public health.

# 5 CONCLUSION AND RECOMMENDATIONS

**The public health transfer from the NHS to local government has provided, and continues to provide, local government with real opportunities, not only to improve public health by considering the wider determinants of public health, but to reinvigorate other local government departments by starting conversations, joining up services and drawing on specific public health skills.**

There have, of course, been challenges since the public health transfer. This report has detailed the structural difficulties that local government and public health teams have faced and perhaps more significantly the cultural challenges that public health teams have experienced. The enormity of the public health transfer is not to be underestimated. Transferring a large workforce, on different pay-scales from one institution to another (each with their own specific cultures) has been a significant test. However, our research has also shown that, in most cases, public health teams and local government officers feel that the logistical transfer, at least, has gone well and was well planned albeit with some ongoing challenges.

Our report has also shown that, in general, public health is beginning to be embedded within local government. The extent to which this has happened varies amongst authorities and is generally dependent on when the public health team physically moved over to the local authority. The continued success of public health within local government will be based on increasing face to face dialogues and 'water cooler conversations'. It is to be expected, therefore, that councils that were early implementers are slightly more advanced at embedding the public health team within the authority. However, while integration with other local government departments has begun, there is still more work to do to engage with wider stakeholders. This is an opportunity that should not be missed as it is through these community groups that public health messages will be embedded and sustained within the community.



Whilst new conversations have generated new ideas and greater relationships of trust amongst the public health teams and wider council departments, few new services or campaigns have begun. In general, the public health budget has been pre-committed with existing contracts and these contracts have been transferred from the NHS to local government. It is only when these contracts begin to end that the budget will begin to be spent on the new health and wellbeing priorities that reflect the wider determinants of public health.

## 5.1 RECOMMENDATIONS

One of the difficulties of making recommendations on a subject as wide ranging as public health is that every local authority is different, every local authority will have its own specific public health issues and priorities and every local authority will have its own structure. To make recommendations that are too specific and operational is against the very nature of localism. The report contains numerous examples that will be helpful to local authorities, from mechanisms of engagement to discussing overcoming cultural challenges. These examples can be used by local authorities and tailored to their individual needs.

The following, however, are strategic recommendations that reflect the research findings and challenges that we found in every local authority. They are points for all councils to reflect on when considering the public health transfer, priorities and future.

### ■ **Strong leadership to create horizontal networks**

If conversations and trusting relationships are to be built and succeed, those leading the public health agenda need to demonstrate strong leadership skills to increase and cement networks horizontally across the authority, other councils and partner bodies. It is important that those leading the public health transition (both members and officers) are at the forefront of making strategic relationships. With this in mind it is essential that Directors of Public Health are on an equal footing with other directors within the authority. Our research has shown that one of the most effective ways to implement this is for the Department of

Public Health to sit within the Chief Executive's Office. In this way DPHs will be party to strategic conversations within the local authority. This will also be important when addressing the cultural challenge that public health teams have faced. It is confident leadership that will create key conversations and relationships of trust that will see through issues of cultural change.

### ■ **Creating space for councils to innovate**

This report has shown a disparity between public health priorities and public health spending. In part this is due to the public health budget being tied up in contracts that have been carried over from the NHS. As noted, this is likely to cause frustration amongst members as, while they appear to have engaged well with the public health agenda, they will find themselves and their new priorities confined by contracts that have already been signed. If public health is to be truly embedded within local authorities, it is essential that councils create the space and funding to innovate public health and create change. Public health objectives should be resourced from beyond the bounds of public health and a small part of the public health budget and other council budgets should be targeted to create a council innovation budget that could be used by all tiers of local government to pilot and trial ideas. This system of community budgets has been used to create and trial innovative programmes amongst the district councils in Leicestershire as well as to create more trusting relationships. This should be expanded so that departments within upper-tier authorities and unitary councils can similarly innovate. In order for public health to become more preventative, the wider determinants of public health will need to be tackled more 'upstream' and with other departments. If this is a success, the preventative programmes could result in significant savings for local authorities.

### ■ **Co-design of services within the community**

Public health needs to be embedded, not only within local authorities, but with the local communities. For public health to truly work it needs to be implemented through bottom-up engagement with wider stakeholders and public engagement. Throughout our research we found that those we spoke to, from senior officers to the community and voluntary sector, felt that local authorities need to move towards co-designing services with residents and local community groups; it is intuitive that if issues

are to be tackled this should be done with local knowledge and support. CCG locality groups and local health and wellbeing forums that have already been set up are well placed to co-design services and create bottom-up services that can be embedded within communities. With the exception of national campaigns and statutory requirements, the public health budget should be allocated through these locality groups.

### ■ **Continuous Evolution**

One of the successes of the public health transfer has been the new relationships and greater trust that has been formed between different departments within the council, the public health team and the CCGs. Despite the challenges, this 'shake up' of the existing system has led to greater dialogue which has in turn resulted in innovative programmes being suggested, old contracts being reviewed and duplications being noted. However, the previous six months has undoubtedly been a golden age where public health teams have created new conversations while still maintaining old relationships that they had within the PCT, particularly with the CCGs. It is essential that these relationships continue to be maintained and the connections that public health teams make within local government are not to the detriment of the previous relationships they had within the NHS. In addition to this, we recommend a 'continuous evolution' of reviewing contracts and de-duplicating services to ensure that services and programmes are always as innovative as possible.

If councils can implement these strategic recommendations successfully, the public health portfolio will have the potential to open up a whole new way of working for local authorities. Councils need to assess their public health outcomes and begin to feed these into their strategic priorities. Locally the wider determinants of poor public health will have been identified and tackling these will be the first point in tackling wider social issues. If problems can be identified earlier there will be less pressure, both in terms of capacity and financially on other local government departments and at a time of constant budget cuts, public health may provide the preventative key that local authorities need.

# APPENDIX 1: METHODOLOGY

**The methodology for this research had four main components:**

- 1.** A survey was sent to over 1000 senior officers throughout unitary, county and district councils in England. These officers were not confined to any particular department, as we wanted to gather a broad view of how public health was being integrated into local government. In addition to this, we sent the survey to health and wellbeing board members throughout England, and for those that we did not have contact details for, we asked for the survey link to be passed on. In total 166 people answered our survey, although, as indicated on each chart, this varied depending on the question.
- 2.** We selected 10 survey respondents and carried out an in depth telephone interview with each.
- 3.** We visited and case studied four councils: Surrey County Council, Leicestershire County Council, Sunderland City Council and the London Borough of Hounslow. These areas represented different regions of England, unitary and two-tier councils and also areas that differed socio-demographically. This ensured that we gained the broadest possible view of the public health transfer.
- 4.** Finally, we held a roundtable with senior officers from throughout the council, including Directors of Public Health, to sense check our research findings and discuss the way forward for public health.

# APPENDIX 2: LIST OF ACRONYMS

- CCG – Clinical Commissioning Group
- DPH – Director of Public Health
- HWB Board – Health and Wellbeing Board
- JSNA – Joint Strategic Needs Assessment
- NHS – National Health Service
- PCT – Primary Care Trust
- REDe – Regeneration, Economic Development and Environment
- VCS – Voluntary and Community Sector





**In April, local government regained its responsibility for public health. For the first time in a generation, councils now have direct responsibility for co-ordinating action to prevent illness and to improve the health of their communities. These changes have placed local authorities in a pivotal position where they can integrate public health with council services such as housing, planning and transport, co-ordinate spending decisions on ‘traditional’ health promotion and health protection measures with action on the wider determinants of health.**

This report looks at the challenges, difficulties and solutions that public health teams have experienced during, and since, the public health transfer. It also examines the extent to which public health has been integrated into local government and looks at whether the public health transfer and integration has had an impact on public health priorities and spending.

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