Appendix 2 (a)

PUBLIC HEALTH, WELLNESS & CULTURE SCRUTINY PANEL

The Role of the Local Authority in Health Issues

FINAL REPORT

Foreword

This report has identified specific opportunities afforded by the transformational changes to public health and the wider health landscape, relating to the role of individuals and communities, innovation, developing effective approaches, accountability, and partnership working.

All of the witnesses we talked to were encouraged that responsibility for public health has been transferred. The transfer of public health into the local authority offers opportunities to achieve positive changes. It has the potential to build on the understanding that local authorities have about their neighbourhoods which can be harnessed to support positive changes in both physical and mental well being.

We are encouraged by the degree of commitment shown in tackling health inequalities, particularly through the GP consortia working closely with the local authority to join up commissioning for health improvement and the health and well-being board will play an important role in making this happen.

All public sector staff can contribute to health improvement through their own jobs with every individual being clear about how they can take responsibility for their own health.

In these key transition months and years, we need to ensure that all parts of the Public Health function are placed appropriately to continue to secure the public's health, safety and wellbeing over the next three to five years and into the future.

Councillor George Howe
Lead Scrutiny Member, Public Health, Wellness and Culture

1. The introduction of a public health role for councils

1.1 From 1 April 2013 local authorities will assume responsibilities for public health. Health and wellbeing boards will be established as statutory committees responsible for encouraging integrated working and joint strategies on health and wellbeing. The decision to move responsibility for public health to the local authority and specifically to a local level is a welcome one.

1.2 Local authorities were the originators of many of the public health interventions and were responsible for the roots of public health improvement. Post-1974, medical officers of health moved out of local government and into the NHS. In many respects public health has become synonymous with ill health, and local authorities will need to try to address the causes of ill health through prevention. Local authorities are best placed to do that through their community leadership role.

1.3 The Department of Health Public Health Outcomes Framework emphasises the importance of the broader determinants of health and sets out the indicators under four categories, one of which is specifically dedicated to the wider determinants of health. Since levels of health inequalities relate closely to levels of inequalities in the social determinants of health (SDH), major improvements in public health will not occur without action to reduce inequalities in the social determinants of health.

1.4 The Marmot Review[1] proposed intervening in six areas which cover all the wider determinants: early years, skills and education, employment and work, minimum income for healthy living, the physical and social environment, and ill-health prevention, while ensuring that policies and intervention are underpinned by the principles of equality and health equity.

2. **Aim of the Review**

2.1 The review looked at the development of a local public health system that is designed to have the greatest potential for improving health, not just within the council but with all local partners. The focus was on transformation, looking at how the council and public health are going beyond the practical steps of transition to develop a local vision for public health.

3. **Terms of Reference**

3.1 The Panel agreed the following terms of reference:

- To explore how the new arrangements can have a greater impact on key health outcomes such as smoking, alcohol and obesity;
- To identify how commissioners can make best use of their available resources to improve local health and wellbeing outcomes in the short, medium and long-term.

[1] Fair Society, Healthy Lives' Professor Michael Marmot's February 2010

- To assess the opportunities to align strategies and commissioning with other parts of the local system impacting upon the broad public health programme.

4. **Membership of the Scrutiny Panel**

4.1 Members of the Panel:

Lead Scrutiny Member, Cllr George Howe
Cllrs Dianne Snowdon, Debra Waller, Louise Farthing, Fiona Miller, Julia Jackson, Rebecca Atkinson and Paul Maddison (from December 2012)

5. Methods of Investigation

5.1 The Scrutiny Panel has considered information contained in national legislation, guidance and research, taken evidence from those involved in the transition of public health, and considered good practice examples.

6. Setting the Scene

> *"Local leadership for public health will be at the heart of the new public health system. Local authorities should embed these new public health functions into all their activities, tailoring local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities. They will create a 21st century local public health system, based on localism, democratic accountability and evidence"*[2]

6.1 The Government has undertaken wide-ranging reforms through the *Health and Social Care Act* (March 2012). Local leadership will be at the heart of the new public health system, with local authorities taking on significant new public health functions from 1st April 2013 for health improvement and health protection, backed by a ring-fenced budget.

6.2 Although required to provide a small number of mandatory services, such as NHS health checks and the National Child Measurement Programme, local authorities will be free to determine their own priorities and services, tailoring local solutions to local problems and using all levers at their disposal to improve health and reduce inequalities.

6.3 There are some critically important health issues for Sunderland. Life expectancy generally is lower than the England average and also differs significantly between wards within the city. Life expectancy in Sunderland is 10.9 years lower for men and 7 years lower for women in the most deprived areas of the city than in the least deprived areas.

6.4 Levels of teenage pregnancy, alcohol specific hospital stays among those under 18, smoking in pregnancy, levels of 'healthy eating', smoking and obesity are all worse in the city than the England average.

6.5 Priority actions for Sunderland include early cancer awareness, diagnosis and intervention around best start in life and early intervention.

[2] The new public health role of local authorities, Department of Health, October 2012

6.6 Significant progress has been made on a number of issues:

- in recent years, life expectancy has been rising faster in the North East than in any region except London;
- cardiovascular disease has been falling more quickly than the national average; and
- smoking prevalence has fallen dramatically since 2005.

6.7 Yet health inequalities still exist. To give just a few examples:

- 37% of the population of Sunderland live in areas that are among the 20% most disadvantaged across England;
- Among males, all cancers account for a much larger proportion of the life expectancy gap when compared to the average local authority.

6.8 The local authority will need to bring together partners and coordinate action across the field of public health. Integration is a key driver for the current changes and its realisation will arguably be the biggest challenge over the coming decade. These fundamental changes provide an excellent opportunity to rethink the approach to the key domains of public health and to develop a strategic focus on improving access to health and improving health outcomes.

7. Findings of the Panel

<u>The adequacy of preparations for the new arrangements</u>

7.1 The Sunderland health and well-being early implementer board has been meeting regularly prior to the health and well-being board being established. This became the shadow health and wellbeing board in April 2012 and aims to ensure engagement, joint working and decision making with all relevant health partners during the transition process which also includes the transition of public health as well as the formulation of formal clinical commissioning group (CCG) and the development of national bodies such as Public Health England the Clinical Commissioning Board.

7.2 At the time of our review, the new arrangements were at the transition and transformation stage. Planning, discussion and consultation were taking place. The joint strategic needs assessment (JSNA) is beginning to drive the agenda for understanding the health and wellbeing needs of the city and the emergence of a clear understanding about roles and responsibilities is expected, but we are not there yet. Once established, there will be a need to provide the tools and information for councillors in their new role as public health champions.

7.3 The Panel considered how the council in its community leadership role can make best use of its network of community coalitions to achieve a broad-based public health approach so that public health becomes everyone's business.

7.4 First of all, the way that the local authority defines public health will be vital in determining how it interprets, and acts upon its new responsibilities. Public Health is defined as promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.

7.5 The leadership role of councillors at local and strategic level, as members of the health and wellbeing board, members of scrutiny, and leaders in their local area to engage with and develop communities to address their needs for health and wellbeing can create a local model that looks more broadly at the 'health of the public'.

7.6 The Panel would certainly want to see health as an issue of civic pride for the council with increased life expectancy to be achieved for the residents in those wards with less good outcomes. It should be regarded by everyone as unacceptable if the life expectancy of certain residents is not as good as it is in other parts of the city.

7.7 For this to be achieved the Panel recommends that all councillors need to be fully engaged in the new public health agenda (and understand the determinants of good health and wellbeing as well as understanding the gaps and inequalities between Sunderland and the rest of England as well as at a locality level) by being given both the skills and understanding of how to facilitate effective interventions in a public health framework so that it can be seen as a core part of the councils work.

Accountability and measuring impact

7.8 The Panel was informed that the emphasis should be on outcomes rather than processes. The shadow health and wellbeing board has been getting its systems in place, working out the links between the JSNA and the emerging health and wellbeing strategy. The Panel considered the next steps are for the board to consider how it will achieve community engagement and how it will apply an appropriate and realistic approach to accountability.

7.9 If the reforms are genuinely about shaping services around the needs of individuals and communities, then service users and the public must have real influence when big decisions are made.

7.10 A clear connection between health and wellbeing boards and the public involvement agenda is the membership of local authority elected members on the board.

7.11 Local Healthwatch will have seat on the board, but that's not enough; public engagement needs to be embedded in the way the board operates. The board will be making some contentious decisions. If the public are to accept these decisions, they need to feel that decision makers have listened to their views.

7.12 One crucial opportunity for health and wellbeing boards is to support the development of local Healthwatch. Healthwatch will have a formal role of involving the public in major decision making around health and social care. Some clarity is required between the role of local Healthwatch in representing the views of the public, and the role of local authority members as elected representatives of that same public on the board and the role of scrutiny members in their community consultation.

7.13 Like the boards themselves, CCGs will draw part of their legitimacy from the way they involve the public. As they develop their role they will be developing their own means of engaging the public in their planning and decision-making.

7.14 One tension may be about cultural differences; the NHS members of the board may not be used to working in a political environment, and board members will need to spend time to share and understand each others' viewpoint.

7.15 The health and wellbeing board will need to determine their own evaluation mechanisms to assess their performance. This may include tangible measures, for example monitoring success against the NHS outcomes frameworks. Some may be less tangible, such as evaluating whether partnership arrangements are working well.

7.16 The health and wellbeing board and overview and scrutiny both have core roles to play in monitoring local performance; however, it is not yet clear what will happen if the local authority fails to prioritise public health or take appropriate actions.

7.17 The Panel recommends the development of robust local accountability structures for all relevant aspects of health and wellbeing decision-making and delivery.

7.18 Furthermore, the Panel believes that there would be value in including, within an outcome framework, measures that are linked to the health and wellbeing of the public sector workforce. Such measures would include staff access to occupational health services, as these are now shown to have an impact on the quality of services and care delivered for patients.

7.19 The Panel was informed that historically strategies have not engaged systematically with an asset based approach to health improvement, but the joint health and well-being strategy has set out to gain an understanding of what assets we have, what level of successes and good outcomes already exist and for whom. For example, 75% of pregnant women don't smoke and the approach would be to consider what motivation drives the majority rather than emphasising the 25% of pregnant women who do smoke. The strategy was developed after a series of consultation events to gain a better understanding of our assets.

7.20 The Panel supported this asset-based approach, but commented that this does not automatically tackle inequalities. Whilst acknowledging the evidence showing that beginning with a focus on what communities have (their assets) as opposed to what they don't have (their needs) a community's efficacy in addressing its own needs increases. The Panel has serious concerns about the destabilising of our assets for example welfare reforms may be counterproductive for the health and wellbeing of some vulnerable sectors of the population.

7.21 The Panel recommends that the strategic approach should tie in fundamentally with community resilience at a time when our 'assets' are under serious threat of being destabilised by external factors such as the reform of welfare support. An asset based approach should pro-actively consider how inequalities can be addressed, with due regard given to equalities in all decision making.

Resilience Arrangements at the Local Level

7.22 While there are real opportunities for improving health, local services do not operate in a vacuum and external factors can have the largest influence upon people's wellbeing.

7.23 The Panel agrees with Professor Sir Michael Marmot's analysis that the crucial determinants of health are: "… the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

7.24 Poverty and low living standards are powerful causes of poor health and health inequalities. The impact of the financial climate could have significant implications for the health status of the least well off in the city.

7.25 The Panel felt that they would wish to see the targeting of appropriate areas or communities to work in and allowing enough time for communities to build their confidence and their networks locally.

7.26 The Panel heard that joining up an asset-based approach and locality working would support the integration of public health as 'everyone's business'.

7.27 Applying 'localism' to the public health agenda means that each area will determine their priorities for health improvement based on their particular assets, needs and circumstances. There is a risk that this could be perceived as a 'post code lottery' when, in fact, it should be the expression of significant local differences.

7.28 Sunderland's Clinical Commissioning Group will be organised around the council's five locality areas. Each of the council's five area committees has a public health-related priority within its annual work programme. The council's recently established Place and People Boards have the potential to use this priority planning to encourage innovation and creativity at local level. This local influence should help to determine what a healthy community looks like with improved access to health improvement services and a particular focus on priority neighbourhoods.

7.29 The Panel learned of innovative examples of interventions that have impacted positively on people's health locally.

- Sunderland Health Champions are people who are in regular contact with members of the community and can potentially influence health choices. They are also trained, for example, in undertaking brief intervention in relation to smoking and alcohol so that they can signpost people on to the appropriate services. A further development could be targeting areas of greatest priority e.g. men's health and older and younger people. The potential reach of workplace initiatives also presents huge opportunities to access to priority groups including young men. The pool of Health Champions could be grown by inviting potential willing volunteers such as those people participating in Community Spirit (1000 members) and Gentoo Residents Involvement Network (700 members) to also become Health Champions. The Customer Service Network (100) are also to be trained as Health Champions.

- Sunderland's overarching approach to 'Strengthening Families' seeks to ensure that families in Sunderland can easily access the right support, at the right time and in the right way to enable them to meet their needs and make the best use of all resources available. This will include identifying and building on families' strengths, helping them to recognise and fulfil their potential and make a positive contribution to their community.

7.30 A critical consideration is how information is communicated. An online guide has been launched for the South of Tyne and Wear which is designed to give advice and information about how to keep "mind and body healthy and where to find help if you have a problem" equity of access is important and whilst web based information has a role to play, this will not hit the hard to reach cohorts of the population who may not have internet access. Health information must be delivered through a range of mediums, including letter, email, texts, social networking, posters etc. Panel members made the point that community pharmacies can also play a role in the provision of public health information.

7.31 The Panel heard that work on community resilience aims to build self-resilience within communities. The previous model leads to dependency on health services, whereas resilience builds self-help. Panel members felt strongly that this needs to be made as easy as possible for people. For example, personalised budgets are a form of self-help but service users need support to be guided through making the most of the potential available to them.

7.32 The Panel would like to see more evidence of a 'theory of change' that explains how the inputs will produce the outputs at local level, that is, more evidence of tangible, practical delivery and targeting appropriate areas or communities to work in. The Panel strongly recommends increasing the local asset base by growing the number of Health Champions and maximising the use of community assets and settings to deliver health and well-being services.

<u>The coordinating role of the health and wellbeing board</u>

7.33 The Department of Health's public health strategy emphasises that the shift to local authorities should increase accountability, with the role of elected members being crucial. This should incorporate existing governance structures, including the work of overview and scrutiny and also embrace new roles and relationships, particularly through the coordinating role of the health and wellbeing board. For example, joint working between GPs and local councils has often been patchy. There are some real opportunities with GPs and local councillors as they come to the health and wellbeing board.

7.34 There are some questions of clarity about the relationship between the health and wellbeing board and the rest of the governance structures within the council. It is hoped that the health and wellbeing board will be in a position to achieve positive health behaviours by facilitating the best possible integration of health interventions; however, the Panel recommends that a protocol for working together be developed between key stakeholders including the Health and Wellbeing Board, Adult Partnership Board, Children's Trust,

Clinical Commissioning Group, HealthWatch, NHS Partners, National Commissioning Board and the Scrutiny Committee. The protocol could include information sharing, communication, engagement reporting mechanisms and organisational liaison.

7.35 Overview and scrutiny has been heavily involved in establishing evidence-based reviews around inequalities in health balancing use of good data and professional evidence with views of individuals and communities to provide opportunities for 'co-producing' solutions. Recent scrutiny reviews have used appreciative inquiry to target issues such as alcohol and drugs, unemployment, housing, sexual health, and mental health.

> *"What is clear is that the work of scrutiny has demonstrated that it can bring an added dimension when trying to understand the complexities of health inequalities – something that can enhance what professionals are already trying to do."*
> Peeling the onion: Learning, tips and tools from the Health Inequalities CFPS 2012

7.36 Using scrutiny in this way brings new challenges to existing mechanisms and allows lay people to put forward a different perspective.

7.37 The Panel felt that there is still a risk that public health will not necessarily be viewed within the whole of the strategic content. One of the challenges for the board will be looking at existing council plans, setting out the council's ambition, and asking whether they see their leadership role for health as testing the health focus of each council plan.

<u>Promoting better public health through wider roles and responsibilities</u>

7.38 The Panel received evidence that health is determined by numerous factors, many of which are beyond the scope and influence of individual service provision. It was clear that a public health focus should be built into all relevant organisational strategies, approaches and budgetary discussions. This can be best achieved from having a fully integrated partnership approach across all three domains of public health.

7.39 Health is a priority of the Sunderland Strategy 2008-2025. All policies which flow from the overarching strategy should form part of an integrated policy tackling the wider determinants of health such as alcohol, smoking and obesity.

7.40 For example, the Children and Young People's Plan which offers a variety of extended services, the Core Strategy promotes healthy environments and lifestyles. The wide variety, quality and quantity of green infrastructure in Sunderland contributes significantly towards the creation of safer, healthier and more sustainable neighbourhoods, and in turn will protect and improve resident's health and welfare. Local authority regulatory services such as trading standards; food safety; and licensing and gambling also impact on health. Other links between the council, community and health concerns include the health gains from addressing fuel poverty and promoting energy efficiency.

7.41 Consideration of the planning and regulatory framework to provide an holistic approach to tackling concerns over community health can be applied by consideration of a particular priority such as obesity.

7.42 Obesity is a significant social and health issue which has reached increasing levels of concern. Currently one in four adults, and over one in ten children aged 2-10 in England are obese. Of especial concern is the increasing incidence childhood obesity. Government guidance[3] aimed at promoting healthier communities, encourages planning authorities to control the over proliferation of fast food outlets within their area. For example, some Council's seek to restrict the number of new hot food takeaways within 5 minute walk of primary and secondary schools.

Case Study – Halton Borough Council
Hot Food Takeaway – Supplementary Planning Document
The SPD assists in the contribution that planning can make to the health of residents by addressing the over–abundance of hot food takeaways. It is used as a guide for applicants seeking planning permission for Hot Food Takeaways in close proximity to Schools, Playing Fields and Outdoor play-spaces

7.43 This is an example of the type of opportunity to start to address some of the preventative care issues from a whole-place perspective. The structures and relationships developed now will help to address inequalities in health over a much longer period of time. The Panel strongly recommends that public health and regulatory staff working together to explore what the regulations will allow in terms of health benefits within the regulatory framework.

7.44 The Panel understands the huge scale of the public health reforms. It is known that concentrations of deprivation magnify problems associated with poverty and increase the likelihood of household members falling victim to crime, having lower educational attainment, suffering higher levels of mental and physical ill-health, suffering shortened life and so on. Strategies which seek to address such decline and provide sustainable communities can therefore positively affect relative health levels.

7.45 The Panel heard that consideration of public health at the earliest stages of planning and design can ultimately lead to a healthier population.

7.46 The World Health Organisation (WHO) Healthy Cities programme promotes policy and planning with an emphasis on health inequalities and urban poverty. It strives to include health considerations in economic, regeneration and urban development efforts. The WHO vision for an age-friendly city is **o**ne that enables older people to remain active within their communities. Streets should be welcoming places that are accessible for everyone. That means well maintained pavements to avoid trip hazards, cleanliness, seating, provision of public toilets, and local access to a range of local services. The four cornerstones are: Place, (including environment, housing and transport); People,(including the social attitudes of the community); Resource, (including shops, leisure, faith); and Networks (how people work together to support older people both nationally and locally).

[3] HM Government, Healthy Weight Healthy Lives (2008); Healthy Lives Healthy People: Our strategy for Public Health in England (November 2010)

7.47 The overarching theme for the current phase is health equity in all local policies. Health in all policies is based on a recognition that population health is largely determined by policies and actions beyond the health sector. Health in all policies addresses the influence of transport, housing and urban development, the environment, education, agriculture, fiscal policies, tax policies and economic policies.

7.48 While planning policy can support a healthy population by providing a supply of good quality homes, preventing and reducing pollution, a high quality pedestrian and cycle friendly environment and the support of active recreation, it is considered that some development, particularly large schemes, may have negative impacts on health.

7.49 The Panel heard evidence that Health Impact Assessment (HIA) is increasingly seen as a useful tool with which health impacts of policies, programmes and interventions, and their distribution across the population can be assessed in order to enhance the positive and reduce negative health impacts.

7.50 HIA's have arisen out of the need, on the one hand, for planning to act as a more strategic, proactive force for economic, social and environmental well-being, and on the other for health planning to recognise that a wide range of factors in addition to simply the provision of health services are important for determining public health. Currently, there is no statutory requirement to undertake an HIA, unlike the equalities assessment.

7.51 The Panel was informed that Teaching Primary Care Trust staff have received training to implement assessments. Discussions have taken place with planners to raise the profile of HIA and for consideration to be given for the use of HIA in future planning applications. The new arrangements provide significant opportunities to develop a policy on systematic health impact assessment of major council decisions and to embed equality and health equity in all council policies. The Panel strongly recommends the exploration of bringing together both impact assessments, thereby integrating health impact assessments and equality analysis.

8. Conclusions

8.1 The transfer of public health from the NHS to local government has been welcomed. It is local government services, such as housing and environmental health, that have the most significant impact on public health outcomes.

8.2 However, local government is receiving responsibility for public health at a challenging time. On the one hand, local government faces a significant increase in demand. Cases of diabetes, dementia and heart disease are set to increase rapidly. On the other hand, councils face a significant reduction in resource and this is compounded by the government's proposals for allocating the public health budget that could see deprived areas receiving less than the previous investment.

8.3 Public health presents a compelling challenge for local government. Issues such as alcohol, tobacco and obesity, often underpinned by poor mental health, exert an enormous toll in both financial and human terms. The evidence presented in this report suggests that meeting these challenges will

require local authorities to pioneer a bottom up approach to public health improvement that is characterised by early intervention, self-management and co-production.

8.4 The Panel hopes that this report will contribute towards the debate about what effective local government leadership of public health looks like.

8.5 To realise the full potential of the transfer of public health, and meet the current resource challenge, local government will need to:

- Integrate public health across all service areas
- Help communities to provide services for themselves
- Invest in prevention.

8.6 This report examines these aims and provides recommendations to advance them. The recommendations are listed below.

9. Recommendations

9.1 The Committees key recommendations to the Cabinet are as outlined below:

(a) All councillors to be fully engaged in the emerging public health agenda by being given both the skills and understanding of how to facilitate effective interventions in a public health framework.

(b) Robust local accountability structures should be developed for all relevant aspects of health and wellbeing decision-making and delivery.

(c) The joint health strategy should demonstrate a tie in with community resilience at a time when our 'assets' are under serious threat of being destabilised by external factors.

(d) The local asset base should be increased by growing the number of Health Champions and maximising the use of community assets and settings to deliver health and well-being services.

(e) A protocol for working together should be developed between key stakeholders.

(f) Public health and regulatory staff should work together to explore what the regulations will allow in terms of health benefits.

(g) Explore the integration of health impact assessments and equality analysis.

10. Acknowledgements

The Panel is grateful to all those who have presented evidence during the course of the review. We would like to place on record our appreciation in particular of the willingness and cooperation we have received from those named below:

(a) Sarah Reed, Assistant Chief Executive
(b) Gillian Gibson, Public Health Consultant
(c) Vince Taylor, Head of Strategy & Performance

(d) Karen Graham, Associate Policy Lead for Health
(e) Jane Hibberd, Head of Strategy and Policy for People & Neighbourhoods

11. **Background Papers**

(a) Healthy lives, healthy people : our strategy for public health in England - DH 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf
(b) Health and Social Care Act 2012
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
(c) Healthy lives, healthy people : improving outcomes and supporting transparency: A public health outcomes framework for England, 2013-2016
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
(d) Fair Society, Healthy Lives - Professor Michael Marmot February 2010
http://www.instituteofhealthequity.org/

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