In Sickness and in Health

Assessing the transition to a more localist health system – the first step towards marriage between the NHS and local government?

Gwilym Tudor Jones

Foreword by Prof. Sir Michael Marmot

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Prior to joining Localis as a Research Fellow, Gwilym Tudor Jones provided briefings and analysis on government policy in the private sector. He has a broad range of political and policy interests including public service reform, strategic commissioning and procurement, and international relations. Since joining, he has written columns in the Guardian online on health reform and the future of councils. Gwilym has an MPhil from the University of Cambridge, writing his thesis on the role of religion in the Rwandan genocide, interviewing thirty genocide survivors in Kigali.

Foreword

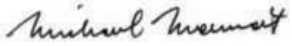
The evidence shows that social, economic and environmental factors all contribute to health. Early years experiences, the amount of control that individuals have over their lives, the quality of their job, the amount of income that they receive, and the quality of their physical and social environment can all impact on mental and physical health and the length of their lives. At the Institute of Health Equity, we work with many local areas, to learn from them and, in turn, inform their activities. Now, over 75% of local authorities have local strategies that are explicitly aiming to reduce health inequalities based on the recommendations I made in *Fair Society, Healthy Lives*.

Indeed, local government has a long history of working to improve the health, and reduce the inequalities, of local populations. They have the opportunity to influence areas such as housing, transport, and the quality of the local environment. These can have important effects on people's lives and I have consistently seen inspiring and successful activities by local authorities that are making a real difference. But now, we have real change in the way in which local authorities work with the introduction of the 2012 Health and Social Care Act. I believe that this act provides many opportunities, as well as challenges. The move of public health to local government is a positive development. Local authorities now have the opportunity to more easily tackle health inequalities in coherent and collaborative ways. This joint working is key to addressing health inequalities which are driven by a complex interaction of economic, social, and environmental inequalities.

Of course, there will be challenges. Change requires courage – to work with new colleagues in different sectors, breaking down traditional silos. Transitions take time, patience, and enthusiasm.

This important and timely report shows good signs that local authorities are broadly optimistic about the reforms, and are willing and able to work to improve the health and lives of their local populations. By gathering and reporting on a wide range of information and experiences within the local sector, Localis have also been able to provide advice that will give local authorities across England valuable direction and guidance.

If health is to improve, and inequalities reduce, local government action is essential. I think that this programme of work, and the report contained here, will not only be useful to all those working in local government, but will be a source of inspiration and encouragement. Action in this area is so important.



Prof.Sir Michael Marmot | Director, UCL Institute of Health Equity

Executive summary

As part of the Health and Social Care Act 2012, the Government has embarked upon an ambitious programme to improve public health, overseeing a radical restructuring of the national and local management of public health services. The Act, which came into effect on April 1st 2013, witnessed the return of (some) public health responsibilities to local authorities from NHS control, and the creation of Health and Wellbeing Boards (HWBs), enhancing the role of local government in the planning and oversight of local health services. By devolving responsibility to representative councillors, who are elected by local people, the government hopes that services will be better tailored to local needs, and delivered more cheaply and effectively.

The reforms have been shaped by a number of challenges currently facing the NHS, notably: the ageing population; current poor performance on preventable diseases; and persistent health inequalities, even across local authority boundaries. Furthermore, the economic downturn and continued stagnation of the UK economy dictate that there is very limited public money available.

It is against this background that Localis publishes this report, which offers a stocktake – from a local government perspective – of the transition to the new health and public health system, as well as making a number of recommendations to improve the operation and effectiveness of the new system. The report feeds in the results of a survey of over 80 senior local government members and officers, extensive interviews and a roundtable discussion, capturing the initial response of local government to its new role.

There are three key strands to the report. Firstly, we assess the transfer of public health responsibilities from the NHS to local government – whether it is working, what the barriers to a successful transition are, and how they may be overcome. Secondly, we examine the accountability and scrutiny mechanisms in place within the new system – whether local government is being held to account for the money it spends, how effectively HWBs and Clinical Commissioning Groups (CCGs) are working together, and whether HWBs are being subject to sufficient scrutiny. Finally, we explore some of the current and potential future approaches to the delivery of innovative, locally responsive health and public health services. Our key findings are as follows:

1. The transition so far

The good news is that there is plenty of optimism in local government about these changes and a belief that they will lead to improved health outcomes for local residents. This is a confidence shared by many public health teams, who are equally enthusiastic about the transition and the opportunities it presents for delivering real change locally. While acknowledging that, as with any

transformation, it will take time to bed in, in most areas the changeover to the new system has gone well, with the ease of transition being influenced by two main factors. Firstly, local government geography: in 'shire counties' where two-tier arrangements define the local government landscape, their greater organisational complexity has made progress markedly slower. Secondly, the extent of prior collaboration between local authorities and NHS public health teams: as many public health teams and councils work together for the first time, a key challenge has been to overcome their cultural and organisational distinctions. Where such divides exist, we found a number of councils exploring creative new approaches to overcome them.

Another key element of the transition is engaging GPs with the key local actors in the new health and public health system. Our research finds that where GPs are effectively engaged, real gains are being made in delivering joined-up, personalised care. But a number of GPs remain less than fully engaged, not fully convinced of the potential influence they could apply in the new system to improve the provision of health services for their patients.

2. Accountability and scrutiny

The Health and Social Care Act invites HWBs to agree on their own public health performance indicators within the bounds of an overarching national framework, the Public Health Outcomes Framework (PHOF). The new PHOF sets the context for the entire system, from local to national level. People we spoke to both in local government and in public health welcomed the opportunity to determine local priorities while accepting that there are certain proven, nationally important priorities – such as smoking cessation, obesity and sexual health services – relevant to all localities.

The ability of CCGs to work effectively in tandem with HWBs on a shared agenda will be critical to the success or failure of the current reforms. The early signs of how this key relationship is developing were somewhat mixed, with both sides expressing frustrations. In particular, some in local government were concerned that HWBs might not have enough influence over health service commissioning decisions and suggested that they might need to be given greater oversight over commissioning plans to avoid becoming well-meaning 'talking shops'.

Given the integral role of HWBs in shaping the new local health system, it is important that they too are subject to sufficient scrutiny. But how to establish the appropriate mechanisms for holding them to account was a common area of confusion among those we interviewed. Our research found that local Healthwatch organisations, which were established in the 2012 Act to be 'the consumer champion for both health and social care', articulating the public and patient voice – are at varying stages of development across the country.

3. New approaches

The 2012 Act presents local authorities with significant opportunities to work in new ways to deliver truly localised services, both through the tools available to them, such as the newly strengthened Joint Strategic Needs Assessments (JSNAs) – the documents which collate data on local health trends and lay out priorities for action – and the possibilities for greater partnership working, though in both cases data sharing can be a problem.

There is genuine optimism within councils about their prospects for success in promoting integration and joint commissioning at a local level. And our

survey results reveal local authorities broadly ready to work with a range of new partners within the voluntary and private sectors, as well as alongside NHS commissioners.

In particular, our report finds local authorities with a real appetite to focus not just on the traditional big public health issues such as sexual health, obesity, smoking cessation etc., important though they remain, but to also explore ways to tackle the wider social, cultural and environmental determinants of health (e.g. housing, transport, and employment). And as part of this wider approach, it is refreshing to see local authorities considering new and innovative uses of public health funding. Though it is of course vital that they have in place robust mechanisms in order to prove to their local populations that the money is being spent on services that result in demonstrably improved health outcomes.

Looking to the future, there is now cross party agreement that local authorities have a pivotal role to play in forging closer integration of health and social care. For many years this has been one of the holy grails of health policy but it is now backed by strong financial drivers to encourage local authorities to share resources. So it is promising that our research finds local government – through mechanisms such as pooled and community budgets – taking an increasingly active, leading role in forging closer integration.

Our recommendations in summary

- The Government should review the new health system in 2015 to ensure that Health and Wellbeing Boards have real influence over commissioning, and, if their democratic voice is not being heard, consider granting local government greater – even complete – responsibility for health commissioning.
- The Government should consider making the Minister for Public Health a joint DH/Cabinet Office position, in order to aid integration across departmental silos and make a statement that it is embedding public health at the heart of all its policies.
- To enable effective collaboration between local authorities and local partners, the Government should move to a presumption in favour of data sharing for local health bodies.
- It is crucial that local authorities maintain public confidence in the reforms by only spending public health funds on things that are demonstrably related to improving health outcomes for local people.
- Local authorities must seek to broaden local understanding – in a clear and user-friendly format – of what their JSNA is (explaining the data about the area in which they live), what its conclusions are (the health priorities that flow from that data), and what that means for local services.
- A representative body for HWBs – perhaps divided into regional sub-groups – should be created to assure two-way accountability between NHS England and HWBs.
- Local Healthwatch should be given a free role to offer their support or criticism for policies and or their implementation without regulatory or political interference.
- To help foster GP engagement in the new system, we recommend that practices send additional GPs to CCG board meetings when feasible, and that GPs are invited to play a more prominent role in the development of key documents such as JSNAs.
- The Government should maintain its position that strategic commissioning must be 'provider neutral', focusing on local need and the best pathways to deliver services to meet that need.

1. Introduction

April 1st 2013 represented a historic date for local government, marking the long-awaited return of public health responsibilities to local authorities from NHS control. For many, this has been embraced as something of a 'homecoming'. Local government has a long and proud history of involvement in improving the health of its citizens. Indeed in the 19th century, it was local authorities that led the way in addressing the major public health challenges that came with industrialisation, long before the involvement of central government. However, the power of local authorities to manage public health steadily declined and, by 1974, had been taken away completely.

The Health and Social Care Act 2012 led to a radical restructuring of the national and local management of public health services. Local government has been awarded a key role through the assumption of responsibility for the majority of (ring fenced) public health budgets and, crucially, its significant involvement in Health and Wellbeing Boards (HWBs), the new forum for key leaders from local government and the health system to work together at a local level.[1] Further to this, local authorities have, in collaboration with Public Health England (the newly formed national expert body for public health[2]), appointed Directors of Public Health (DsPH) as the principal health advisers for local elected members and officials. DsPH are charged with delivering improved public health outcomes for their local populations. Crucially, they now have the capacity to influence public health from the inside of councils, so helping them affect issues such as alcohol licensing or the prevalence of fast food shops in particular areas.

There are a number of key drivers for the government's reforms, the first being its emphasis on localism.[3] By devolving responsibility to representative councillors, who are elected by local people, and are well placed to know how to spend money locally, the hope is that services provided will be better tailored to local needs, and delivered more cheaply and effectively. A closely related objective is to break down silos within local areas by integrating services across a range of departments and providers – in particular between health and social care.

The reforms have additionally been shaped by demographic and economic necessity. The UK's population is not only growing but ageing, both of which will put increasing strain on our public services in coming years. Spending on adult social care has nearly doubled in twenty years and, if unchecked, threatens to become an unsustainable burden on the NHS and local authorities. The government believes that forging closer links between health and social care at a local level could hold the key to better health outcomes at cheaper costs. In addition to demographic pressures, the economic downturn and continued stagnation of the UK economy dictates that there is very limited public money available – so it is more important than ever before that the maximum 'bang for each buck' is realised.

1. DH, Health and Wellbeing Guide, www.healthandcare.dh.gov.uk/hwb-guide/ (accessed 06/08/13)

2. Department of Health (DH), *Public Health England's Operating Model – Factsheets* (London, 2011)

3. DH, *Public Health in Local Government – Factsheets* (London, 2011)

Importantly, the reforms are also framed by the country's ongoing struggle against poor health outcomes caused, in part, by unhealthy lifestyles. A recent study found that Britain has now fallen behind many Western countries in progress towards managing preventable diseases.[4] The 'big five' killer diseases – heart disease, stroke, cancer, lung and liver disease – account for more than 150,000 deaths a year among under-75s in England; of these the Department of Health estimates that 30,000 are entirely avoidable. 'Traditional' public health services targeting obesity, obesity, sexual health and smoking therefore rightly, we believe, remain a priority.

As a result of these various challenges, the cost of NHS acute care is on an unsustainable trajectory. There has been a growing acceptance of the need for a shift away from the NHS as a crisis management service towards a greater focus on primary and secondary prevention. As one DPH put it, 'the NHS spends a tiny fraction of its budget promoting healthy behaviour and a huge amount treating the results of unhealthy behaviour.'

The Government's public health reforms, which are based on the findings in Sir Michael Marmot's 2010 report 'Fair Society Healthy Lives' (The Marmot Review), recognise the need for local authorities to better tackle the wider social and environmental determinants of health such as housing, planning, transport, social exclusion and poverty in order to minimise future ill health. The reforms therefore require local authorities, with their established links to all relevant local bodies, to formulate a fully coherent public health strategy tailored to local needs and integrated into other areas of local government responsibility. And there is no shortage of optimism – our survey found that more than 6 in 10 respondents thought it 'more likely' that the new health landscape will stimulate a shift towards 'preventative' or 'upstream' measures.

With many in local government welcoming the return of public health to their remit, the most ambitious feel that once they have proven their ability to deliver improved public health outcomes, they should be given scope to assume even greater responsibilities for local health services in the future. However, local authorities spoke of a need for room to 'breathe' over the next few years to

Staying healthy in Essex

4. The Lancet, 'UK health performance: findings of the Global Burden of Disease Study 2010', www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60355-4/abstract (accessed 06/08/13)

develop the new relationships integral to the delivery of cost-effective services and improved health outcomes for their local populations.

Local authorities are not alone in looking ahead to potential further changes to the health system. There is cross-party agreement that HWBs have the potential to improve access, join-up local services, reduce waste, alleviate cost pressures and, most importantly, deliver better patient outcomes – and that there is the potential for local authorities to take on more responsibility, working in ever more innovative and integrated ways. The Government is putting a lot of energy – and money – into supporting a systemic shift to genuine integration of health and social care services, while the Opposition has gone further and floated the idea of 'whole person care', which would see HWBs become the NHS' main commissioning bodies.

This report, which incorporates the results from a survey of over 80 senior local government members and officers, extensive interviews and a roundtable discussion, captures the initial response of local government to its new role.

There are three key strands to the report. Firstly, we assess the transfer of public health responsibilities from the NHS to local government – whether it is working, what the barriers to a successful transition are, and how they may be overcome. Secondly, we examine the accountability and scrutiny mechanisms in place within the new system – whether local government is being held to account for the money it spends, how effectively HWBs and CCGs are working together, and whether HWBs are being subject to sufficient scrutiny. Finally, we explore some of the current and potential future approaches to the delivery of innovative, locally responsive health and public health services.

2. The transition to a new system

'These reforms represent a great opportunity for public health to come of age.'
A Director of Public Health

The good news is that our research finds that local authorities are broadly optimistic about the transition. For one DPH, 'these reforms represent a great opportunity for public health to come of age.' And those in local government are ready to face the challenge of commissioning public health services. On a scale of 1–10, 1 being totally unprepared and 10 being very well prepared, 67% rated themselves between 8 and 10.

This enthusiasm was tempered by a recognition within local government that, as with any transformation, it will take time. As one London councillor put it, 'having been statutory bodies for a month we can't yet evaluate their potential success.' Only 21% responded that HWBs will have an immediate tangible impact on the health of local residents. The long term forecast, however, was positive: nearly two thirds were optimistic that HWBs would eventually deliver improved health outcomes.

This chapter looks at the two main themes in the transfer of public health responsibilities to local government that emerged from our research: how NHS public health teams are coping with the transition to town hall control; and how to encourage wider GP engagement with the new system.

Embedding public health teams into local government culture

Local authorities represent a very different culture from Primary Care Trusts, where DsPH had previously been based. And while all transformations are difficult, there are distinct cultural and organisational distinctions between the health service and local government which make this particular transition challenging. A major challenge facing HWBs will therefore be to overcome these differences and marry what might be termed the social and medical cultures.

How are these cultures different? Whereas the NHS has historically been driven from Whitehall and sees itself as answerable to Ministers, local government is directly accountable to its electorate. Because of this, the two environments inevitably have very different outlooks: while the NHS is not known for looking outside itself to the wider community, by comparison local government is externally focused.[5] Further to this, while the NHS has an inherently clinical mindset, viewing people as 'patients to be treated', local authorities adopt a more holistic approach, tending to see people as citizens and community members.

5. J. Wilderspin, 'Bridging the gap between local government and the NHS', *The Guardian*, www.theguardian.com/healthcare-network/2012/nov/20/local-government-nhs-common-language (accessed 06/08/13)

So how has the transition gone so far? Somewhat predictably there have been a variety of experiences. While in many areas public health teams have slotted seamlessly into the local authority architecture, the process of integration has been a little slower in other places. Our research shows that there have been two main factors influencing the ease of transition: local government geography and the extent of prior collaboration between local authorities and NHS public health teams.

In 'shire counties' where two-tier arrangements define the local government landscape, their greater organisational complexity – having to engage with several CCGs as well as district councils – has made progress markedly slower. The Essex County Council chief executive, for example, has reported that having two tiers heightens the effort required to deliver innovation at ground-level, and in two-tier authorities like Surrey limiting board membership to 20 has been a significant challenge. In contrast, metropolitan boroughs, unitary councils and London metropolitan districts have fewer constituent organisations and a far less complex organisational architecture. Moreover, as a King's Fund report highlights, the expectation that CCGs should be coterminous with HWBs strengthens the partnership between the two and allows for more straightforward membership reporting, and stakeholder involvement.[6]

In some areas, public health and council teams reported extensive collaboration before the transition, whether through shadow HWB arrangements or through having worked together regularly, even in some cases sharing objectives, tasks, managers and office space. The Kent Health Commission, established by Kent County Council (KCC), clearly illustrates this in a number of case studies of prior NHS and local authority partnerships.[7] For example, KCC and Kent and Medway NHS and Social Care Partnership Trust (KMPT) had, prior to the transition date, 'together taken steps to improve the outcomes and experience of people with mental health problems in Kent.' There were also more than 80 joint DPH appointments between local authorities and Primary Care Trusts (PCTs) in place before April 2013.

Other areas reported looser collaborations and even a prior absence of contact which, not surprisingly, has magnified the degree of culture clash. DsPH we interviewed with minimal previous experience of working within a local government context were invariably more uncertain about the transition. One DPH observed that 'health still looks up to the DH not across to local partners.' A number of DsPH also feel that the 'bureaucracy' of local government has hampered their ability to make decisions. A DPH from the North-West of England with a purely NHS background expressed a frustration with the pace of change within councils: 'I understand that it is the democratic process but it has hindered progress. We have to learn new systems and processes, which are more complex and less timely.'

Where such divides exist, a number of councils have adopted creative new approaches to overcome cultural differences. Jim Mcmanus, DPH for Hertfordshire County Council, cites a number of strategies DsPH are using to overcome differences, including induction training and seminars on public health challenges for councillors, and finding a 'good local government mentor.' **We therefore recommend that DsPH new to the town hall culture shadow a council leader to help both sides to understand each other and overcome cultural differences.** One particular worry for some public health professionals is their position within the council. In 2011 Andrew Lansley, then Health Secretary, told Parliament that it was his 'expectation' that DsPH would report directly to council chief executives.[8] And in the great majority of cases, our research

6. R.Humphries et al, *Health and wellbeing boards: System leaders or talking shops?* (The King's Fund, London, 2012), p.15

7. Kent Health Commission et al, *Update report: June 2012,* shareweb.kent.gov.uk/Documents/health-and-wellbeing/Health%20Commission%20-%20Final%20Report%20-%20June%202012.pdf (accessed 29/04/13) p.14

8. Health Service Journal, 'Public health directors 'expected' to report directly to council chief execs, says DH', www.hsj.co.uk/news/policy/public-health-directors-expected-to-report-directly-to-council-chief-execs-says-dh/5032536.article (accessed 06/06/13)

found that the DPH is indeed part of the senior management team. But this is not universally the case[9] and some interviewees argued that DsPH should be directly accountable – by statute – to the chief executive. While we believe it is important for the DPH to have a sufficiently prominent status within the local authority to cut across departmental silos and embed public health at the heart of everything local government departments do, it is too early to conclude that prescribing the precise detail of councils' corporate management arrangements is necessary.

Overall, however, our research finds that most public health teams are enthusiastic about the transition and the opportunities it presents for delivering real change locally. There is also a genuine enthusiasm to bridge the divide between the two sectors and explore new and innovative ways to 'make it work'. The general perception is that as public health and local government colleagues learn to work alongside each other, any negative views will soften and mutual differences will be overcome.

Whitstable Medical Practice

Encouraging GP engagement

The General Practice arm of the NHS is regarded as uniquely well placed not only to provide medical care, but also to promote the health and well-being of their populations and so help address health inequalities.[10] It is to be hoped therefore that as many General Practitioners (GPs) as possible can be persuaded to engage closely with the key local actors in the new health and public health system i.e. local government and Clinical Commissioning Groups (CCGs).

Where GPs are effectively engaged, real gains are being made in delivering joined-up, personalised care. One respondent described the 'can do and engaging' attitude of GPs in his north-London borough in pushing for integration. He described how they have formed 'single assessment teams' of GPs and social workers which collaborate to assess individuals and their needs and then 'come up with a plan to meet those needs.' Such effective local engagement, explained one GP, occurs when 'we can see the benefits for our patients', and not 'because the government is telling us to.' Comments like these illustrate

9. DH, *Government Response to the House of Commons Communities and Local Government Committee Eighth Report of Session 2012–13: The Role of Local Authorities in Health Issues* (The Stationary Office, London, 2013), p.5

10. P. Hutt & S. Gilmour, *Tackling inequalities in general practice* (The King's Fund, London, 2010), p.4

that the traditional NHS top-down model is not always an effective means of engaging GPs.

Of course, it must be emphasised that this year's reforms represent a very substantial change in the status quo for GPs, and it will take time for them to adjust to the new system. But some early indicators of GP involvement in the new system's political process are not very positive.[11] For Dr Peter Holden, General Practitioner Committee negotiator, these results point to the fact that 'the average GP has not realised the power of the CCGs'. Our interviews supported this view, finding GPs not fully aware of the potential influence they could apply in the new system to improve the provision of health services for their patients, with one saying it was more important to 'concentrate on the day job, rather than waste time sitting in CCG meetings'. One DPH pointed to 'time commitments, especially in rural counties where the surgeries are some distance from the county HQ.' as a further barrier to GP engagement. **We therefore suggest that, where practices are widely dispersed, social media and video conferencing could be used to solicit practice engagement and keep in touch with practice populations.**

Council leaders, too, expressed disappointment with the degree of GP involvement, with one describing how he had handwritten letters to every GP in the area, receiving only one reply. Of course, responsibility for strengthening the relationship between individual GPs and HWBs/CCGs is a two way process and local authorities must continue to make efforts to build links with GP practices. But this will only happen if GPs are persuaded that engagement is not an end itself but in the interests of their patients. To facilitate an understanding of the pivotal role local government has to play in the provision of locally responsive health services, and build relationships between local authorities and practices **we recommend that, in addition to the nominated practice lead, practices send additional GPs to CCG board meetings when feasible and that GPs are invited to play a more prominent role in the development of key documents, such as JSNAs.**

11. Pharmaceutical Field, 'Research finds lack of GP enthusiasm over CCG', www.pharmafield.co.uk/news/2011/09/Research-finds-lack-of-GP-enthusiasm-over-CCG (accessed 06/08/13)

3. Accountability and scrutiny in the new system

'Locally set public health targets will always be more meaningful.'
HWB member

The Health and Social Care Act invites HWBs to agree on their own performance indicators for public health within the bounds of an overarching national framework. This move has been widely welcomed by HWBs as it allows them the freedom to measure outcomes set against locally agreed priorities. A further advantage of allowing HWBs to establish their own targets is that, as a number of board members explained to us, it enables them to continually review priorities in response to changing local circumstances.

But with these new freedoms and responsibilities in place, it is vital for local government to be held to account for the money it spends to ensure that services are delivering improved outcomes at a local level. Robust scrutiny mechanisms are also necessary for local authorities to be able to highlight successes and identify areas for potential improvement in order to meet both local and national priorities.

With that in mind, this chapter explores: how the accountability mechanisms are working within the new system, from local to national level; how effectively CCGs and HWBs are working towards a shared agenda; and whether HWBs are being subject to sufficient scrutiny.

Meeting national requirements through local activity

Whereas prior to the reforms the Secretary of State for Health set priorities for the health service for all areas, under the new system local government is given the freedom to set its own public health goals, underpinned by a national Public Health Outcomes Framework (PHOF). The new PHOF sets the context for the entire system, from local to national level. It includes two overarching outcomes: increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities.

Interview respondents at local government level were broadly supportive of the need for a loose, non-prescriptive framework to drive improvements in public health outcomes across the country. The PHOF strikes what we believe is a reasonable balance between allowing the government to emphasise certain proven, nationally important priorities – such as smoking cessation, obesity and

sexual health services – relevant to all localities and allowing local areas to prioritise their particular needs. Importantly, as the Department for Health (DH) states, this freedom encourages local innovation.[12] **The system, we suggest, should be allowed to maintain this balance between national aspirations and specific local need.**

While accepting the need to accommodate national policy objectives, respondents within both local government and public health welcomed the opportunity to determine local priorities. One Home County DPH was happy to be held to account by members on locally derived outcomes 'because Locally set public health targets will always be more meaningful'. A London borough councillor that we interviewed shared this sentiment, adding 'It's good that HWBs haven't been prescribed measures of success.'

A survey funded by the DH found that HWBs' top priorities varied widely, from tackling health inequalities (35%) to integration of services (26%), while 15% of respondents pledged to target specific conditions or services.[13] That such a wide spectrum of local priorities emerged illustrates, we argue, the virtue of allowing local bodies to set their own goals within the broader national context. A further advantage of allowing HWBs to establish their own targets, as a number of board members explained to us, is that it enables them to continually review priorities in response to changing local circumstances.

Despite this grassroots enthusiasm for locally driven health solutions, we did encounter some doubts as to whether future governments would be able to resist the temptation to sidestep the rhetoric of localism and 'meddle' in local public health provision, for instance by expanding the number and scope of national policy imperatives, with the result that local priorities agreed through HWBs became of secondary importance. That said, given the pronouncements of all the main parties on the importance of a more locally-led health system, there is no reason to believe that such a centralising move is imminent.

Another concern encountered in our research is the substantial disparity between public health funding allocations. While some London boroughs receive around £100 per capita, many rural authorities have significantly lower allocations of less than £30 a head, despite the costs associated with delivering services over a large geographical area. Over time, we expect that public health funding will become more evenly distributed across the country.

Councillors working through HWBs in partnership with CCGs

The ability of CCGs to work effectively in tandem with HWBs on a shared agenda will be critical to the success or failure of the current reforms. The early signs are mixed for this new axis of commissioning power. Our findings reveal an array of different relationships developing, with both parties – at times – expressing frustration at an inability to influence decisions. As DH recognises, to succeed HWBs will need to work on the basis of both relationships *and* influence,[14] and all respondents stressed the importance of informal channels of communication. As one council leader put it, 'it's all about what happens in the margins'. Crucially, however, many also asserted that the role of HWBs may, in time, need strengthening.

In particular, respondents to our survey agreed that HWBs would need more robust oversight over commissioning plans if they were not to run the risk of being seen as well-meaning 'talking shops'. Asked in our survey whether HWBs need more powers to influence commissioners, 41% responded 'Yes probably',

12. DH, *Government Response to the House of Commons Communities and Local Government Committee Eighth Report of Session 2012–13: The Role of Local Authorities in Health Issues* (The Stationary Office, London, 2013), p.12

13. National Learning Network for health and wellbeing boards, *Report of the national summit for health and wellbeing boards* www.devonhealthandwellbeing.org.uk/wp-content/uploads/2013/01/Health-and-wellbeing-board-November-event-slide-pack-020113.pdf (accessed 06/08/13)

14. DH, *Government Response to the House of Commons Communities and Local Government Committee Eighth Report of Session 2012–13: The Role of Local Authorities in Health Issues* (The Stationary Office, London, 2013), p.8

while 21% responded 'Yes certainly'. This feeds into a broader concern raised in our interviews that CCGs have no statutory requirement to commission in line with HWB plans. One councillor reported his HWB exercising minimal influence over consortia plans, interaction being 'transactional rather than integrated' as CCGs continually 'override their interests'.

Similarly, there is no requirement for NHS England and its Local Area Teams to adhere to HWB strategy and no mechanism through which they can be directly held to account for their actions.[15] While NHS England does have the capacity to 'take action' when a CCG fails to adhere to a JHWS, HWBs have no direct mechanism through which to challenge CCGs. When challenged on this issue by the Commons CLG Committee, the Government responded that the HWB 'can make this clearly known to the CCG when consulted.'[16] It has recently been announced, however, that HWBs can complain to the Secretary of State if they believe CCGs are ignoring their strategies.[17]

Some HWB members that we interviewed proposed various measures to bolster their influence over commissioning. One DPH proposed a joint commissioning plan (rather than the existing joint strategy) which CCGs have a statutory duty to cooperate with. A councillor we interviewed similarly suggested granting HWBs the power to approve/veto CCG plans. A number of our roundtable attendees went further still and suggested that there is scope for local government to assume greater – even complete – responsibility for commissioning health services. An MP we spoke with said that it was too early to bestow additional powers of this kind, but that if it becomes apparent that the system is not working as intended there would be a need to revisit local government powers. **We therefore recommend that the government conduct a review of the system in 2015 to ensure that HWB influence over commissioning is as intended, making the necessary amendments.** Such a review would be conducted through collaboration between DH, LGA and Monitor.

Despite these fears, others were more pragmatic about existing arrangements. For one councillor, 'It's ultimately down to leadership, relationship management and HWB make-up not powers', while another mused that 'If powers were

New Public Health Team outside Cheshire West and Chester Council

15. Communities and Local Government Committee, *The role of local authorities in health issues Eighth Report of Session 2012–13* (London, 2013), p.77

16. DH, *Government Response to the House of Commons Communities and Local Government Committee Eighth Report of Session 2012–13: The Role of Local Authorities in Health Issues* (The Stationary Office, London, 2013), p.7

17. LGC, 'Hunt to intervene in local health disputes', www.lgcplus.com/briefings/joint-working/health/hunt-to-intervene-in-local-health-disputes/5061674.article?blocktitle=Latest-Local-Government-News&contentID=2249, (accessed 6/08/2013)

required they would in part signal a failure.' Certainly, for the new system to work there will have to be close and continuous engagement between HWBs and CCGs. This, we believe, is inhibited by the government's exclusion of locally elected representatives from CCG board meetings. This is in spite of the fact that HWBs include among their statutory members CCG representatives. DH defended this decision on the grounds that 'CCGs are intended to have a sharp clinical and professional focus.'[18] This focus, we feel, would not in any way be compromised through the presence of a council representative to act as a conduit between HWBs and CCGs and ensure transparency. **We therefore recommend that a HWB representative is invited to attend every CCG board meeting as a participant.**

Furthermore, while a representative of NHS England sits on HWB meetings, this is not reciprocated. Accountability must go both ways. While there are currently three national organisations – PHE, NICE (the National Institute for Health and Care Excellence) and the Local Government Association – responsible for spreading best practice and offering policy advice to councils at a national level, none of these explicitly represent the collective interests of HWBs nationally. For the system to be balanced, NHS England must be held accountable for its own commissioning. **We therefore recommend the formation of a body – perhaps divided into regional sub-groups – representing the interests of HWBs within NHS England.** This would enable repeated failure to commission services in accordance with Joint Health and Wellbeing Strategy (JHWS) to be held to account, as well as helping to identify regional and national trends.

Interestingly, a minority of interviewees put forward the opposite view that 'CCGs aren't robust enough to respond to HWB challenge' with one citing his worry that CCG representatives are 'simply not savvy enough to stand up to elected local politicians.' To help remedy this, and to enhance the capacity of CCGs more broadly, **we suggest that CCGs consider inviting non-executive directors – such as academics and business people – on their boards.** This could bring a range of different viewpoints to discussions and help to provide additional skills e.g. in commissioning.

Local authority health scrutiny

Given the integral role of HWBs in shaping the new local health system, it is crucial that they are subject to sufficient scrutiny. However, the combination of their lack of statutory powers and integral importance in shaping public health policy has made establishing the appropriate mechanisms for holding them to account – whether democratic, procedural or financial – problematic and a common area of confusion among interview respondents.

The Health and Social Care Act 2012 gives councils 'greater flexibility and freedom' to choose how best to undertake health scrutiny powers by conferring on them responsibility for the direct provision of health scrutiny functions.[19] In theory, this is a welcome move and localist in spirit: regulation and scrutiny should indeed take place locally, by those who feel a common concern for local issues and who themselves share the benefits of success and the pain of failure in local health services.

It could be argued, however, that the fact that DsPH who themselves are board members are responsible for informing committees when HWBs perform poorly could undermine the independence of their scrutiny function. It seems counterintuitive to expect DsPH to draw attention to their own failings by flagging problems within their HWB to an external committee rather than to first

18. DH, *Government Response to the House of Commons Communities and Local Government Committee Eighth Report of Session 2012–13: The Role of Local Authorities in Health Issues* (The Stationary Office, London, 2013), p.12

19. This is rather than the more formal Health Overview and Scrutiny Committees (HOSCs) present under the previous government. DH, *Local Authority Health Scrutiny,* www.consultations.dh.gov.uk/public-patient-engagement-experience/http-consultations-dh-gov-uk-ppe-local-authority (accessed 6/08/2013)

attempt to resolve the issue themselves. As one councillor and HWB member has observed, as board members DsPH have 'vested interests', so are unable to provide the robust accountability required of them. Therefore **we recommend that DH must provide further clarity over the role of DsPH given their position as a board member.**

Accountability to the public

Historically, the public have had little input into what and how public health initiatives are rolled out. Prior to the reforms, local public health teams were accountable to NHS colleagues but not to local residents or their representatives. These reforms have the potential to bring significant benefits to local communities by scaling up public involvement through a number of different channels.

Local Healthwatch organisations established in the 2012 Act are 'the consumer champion for both health and social care',[20] intended to articulate the public and patient voice. They offer all local residents, including traditionally marginalised groups, a powerful voice to influence those who run, plan and regulate health and social care services.[21] Our research finds these organisations at varying stages of development across the country. In one case, a council leader described how they invited the voluntary sector to put together a bid to run their local Healthwatch, which they won by developing a consortium of local charities. In order to ensure that they can fulfil their role effectively, **we recommend that the LGA seek to foster a spirit of cross-border collaboration, encouraging areas with a successfully established Local Healthwatch to offer support and advice to those where the transition is proving more difficult.**

Notwithstanding their capacity, if local Healthwatch branches are to do their job, they must have the freedom to represent local residents. However the current regulations prohibit Local Healthwatch from taking part in the 'promotion of, or opposition to, the policy which any governmental or public authority proposes to adopt in relation to any matter'.[22] Malcolm Alexander, Association chair of the National Association of LINks Members, has said the regulation has placed 'unreasonable limits on the freedom of the community to campaign for legislation and local policies that will improve the quality of care'.[23] **We recommend that Local Healthwatch is given a free role to offer their support or criticism for policies and or their implementation without regulatory or political interference.**

Certainly, some local authorities have taken the initiative in empowering residents to express their views and engage in public health. Kirklees Council, for example, conducted a large scale population survey – Current Living in Kirklees (CLiK) 2012 – involving 12,500 adults, garnering a huge amount of information about the health, wellbeing and quality of life of the local adult population to help identify which public health issues and population groups need to be prioritised in the future.[24]

20. Health Watch, *What Is the Healthwatch network?* www.healthwatch.co.uk/sites/default/files/what_is_healthwatch_leaflet.pdf p.1, (accessed 6/08/2013)

21. Ibid

22. DH, *The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012,* www.legislation.gov.uk/uksi/2012/3094/regulation/36/made (accessed 6/08/2013)

23. HSJ, 'Local Healthwatch 'bound and gagged' ,www.hsj.co.uk/news/policy/local-healthwatch-bound-and-gagged/5053509.article (accessed 6/07/2013)

24. Kirklees Council, *Current Living in Kirklees 2012 Survey (CLiK),* www2.kirklees.gov.uk/involve/entry.aspx?id=353 (accessed 6/08/2013)

4. New approaches to health service delivery

'The reforms present a wealth of opportunities to innovate, create, and experiment.'
North London borough councillor

The health reforms present local authorities with significant opportunities to work in new and innovative ways to deliver truly localised services both through the tools available to them, such as the newly strengthened Joint Strategic Needs Assessments (JSNAs), and the possibilities for greater partnership working. As one North London borough councillor put it, 'The reforms present a wealth of opportunities to innovate, create, and experiment.'

Our findings reveal genuine optimism within councils about their prospects for success in promoting integration and joint commissioning at a local level. Respondents were asked about their level of preparedness to work with a range of partners. On a scale of 1–10, 77% rated themselves from 8 to 10 in terms of readiness to work with the third and voluntary sectors, while 71% put their level of preparedness to work alongside NHS commissioners between 8 and 10. That over a third rated their level of readiness for working with new providers at between 8 and 10 highlights a degree of enthusiasm for exploring new ways of working. In addition, over 90 per cent of local authorities (138 of 152) applied to be 'early implementers' and form HWBs well ahead of the required date of April 2012, further demonstrating the real appetite for forging new local partnerships.

This chapter explores some of the current and potential future approaches to the delivery of innovative, locally responsive health and public health services.

How JSNAs are used

JSNAs have been around for several years, but under the recent reforms their purpose has expanded beyond simply describing the health needs of an area to analysing that need and how it should be addressed. As the Department of Health puts it, JSNAs are intended to be 'more than just a collection of evidence' and their mandate goes 'beyond simply quantifying needs to addressing and meeting them.'[25]

However, given the change in their role, it is perhaps unsurprising that there is a mixed picture across the country when one looks at current JSNAs. Some, such as the Essex County Council JSNA 2012, go far beyond presenting the core data on local health needs to analysing the data and identifying important local strategic priorities, including reducing inequalities in life expectancy.[26] Other JSNAs, however, are less outcomes-focused and provide little in the way of data

25. DH, *JSNAs and joint health and wellbeing strategies – draft guidance*, www.media.dh.gov.uk/network/18/files/2012/01/JSNAs-and-joint-health-and-wellbeing-strategies-draft-strats.pdf (assessed 6/08/2013), p.14

26. Essex County Council, *Essex Joint Strategic Needs Assessment*, www.essexinsight.org.uk/get/ShowResourceFile.aspx?ResourceID=299 (accessed 06/08/13), p.58

analysis and strategic insight. Our survey results reflect this confusion with almost 40% of respondents of the opinion that their JSNA was short on data analysis.

While we are confident that all JSNAs will move away from the old data 'dump' model, it may take some time. Given the importance of these documents in determining the expenditure of very substantial amounts of health funding, **we recommend that each local authority seeks to broaden local understanding – in a clear and user-friendly format – of what the JSNA is (explaining the data about the area in which they live), what its conclusions are (the health priorities that flow from that data), and what that means for local services.**

Ensuring JSNAs make good use of data sets

To produce an accurate picture of local health needs, JSNAs should be drawing on a range of data sources from a variety of local partners. Data sharing is therefore crucial for ensuring that those tasked with compiling the JSNA have access to the evidence they need. This is particularly important for protecting people in the most vulnerable circumstances who are excluded from society and often not visible in national datasets.

However, the sharing of health data between local authorities and their partners is a complex issue. While interview respondents showed a clear understanding of the principle that information can be shared either with the explicit consent of the individual or where it is statutorily required, in the absence of these conditions there was uncertainty.

This ambiguity has resulted in local authorities and local partners displaying excessive caution. The very mention of data sharing as a source of frustration was met with a groan of agreement by council chiefs at our roundtable discussion with one council leader saying that 'none of our local partners know what data they can and can't share with us.'

To counter this pressing problem **we recommend that the government make clear that local health bodies should operate under a presumption in favour of data sharing.** In other words, data should be shared unless there are good reasons not to.

Linking the wider determinants of health to public health

Underpinning the government's decision to transfer responsibility for public health from the NHS to local authorities is a desire to look beyond the traditional remit of public health to tackle the 'causes of the causes', or the wider social, cultural and environmental determinants of health. These include (but are by no means limited to) housing, planning, transport, children's services, and employment, for which local authorities (with the exception of employment) already have considerable responsibility. This follows the recommendations of The Marmot Review, which makes clear that many of the health issues facing society today cannot be addressed by the health sector alone but instead require interventions that are aligned and address the wider determinants of health.

Clearly each of these determinants are extensive policy areas on their own and this report does not attempt to analyse any of them in detail. Rather, we explain briefly why each of them is important for health, and offer an illustrative example of how local authorities are looking to improve health outcomes in each of these areas.

Housing

The effects of poor housing on health and wellbeing have been acknowledged for decades by researchers, medical professionals and policy makers. Research suggests that poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety, with the Building Research Establishment (BRE) estimating that poor housing costs the NHS at least £600 million per year.[27]

HWBs have thus far been partially effective in strengthening links with housing representatives. Certainly, our survey revealed a degree of optimism about prospects for integration: 76% of local authority respondents expect to see increased collaboration with housing services.

However, improving the quality of housing is easier said than done. Crucially, local authorities only directly influence a narrow portion of housing, with nearly two thirds of houses owner occupied and therefore beyond the reach of the council.[28] Local authorities only actually own – and therefore have direct influence over – 1.69 million dwellings in England.[29] This represents only 41% of all social housing stock, the remainder being owned by registered providers such as housing associations. Private rented housing, over which local authorities are again able to exert only limited influence, constitutes a growing part of the housing market with nearly 3.8 million homes in England, or 16.5% of all households.[30]

Transport

There is now a body of research firmly demonstrating the health benefits of investing in transport policy. The National Institute for Health and Care Excellence (NICE) provides detailed evidence linking walking and cycling to a number of health benefits.[31] In a March 2013 report, the Department for Transport rightly highlights the need for separate local bodies to work together to provide 'more efficient door-to-door journeys by sustainable transport.'[32] The majority of council leaders we interviewed were aligned to this vision. As one put it, 'we're all in agreement that sustainable, joined up transport is vital for healthier, happier communities.'

Interviewees cited a number of examples of councils delivering highly targeted and joined-up local measures. Plans are in train in a number of areas, for example, for smart, integrated ticketing technology to become the norm. In South Yorkshire a multi-operator ticket, TravelMaster, is now valid on the bus, tram and train networks in the area, and a phased introduction of smart tickets is underway. As the South Yorkshire Public Transport Action Plan (2011–2016) explains, by making public transport more attractive as an option, such measures have the effect of enhancing social inclusion and health, reducing greenhouse gas emissions and maximising safety.[33]

Children's services

Health Minister Dan Poulter has recently made clear that he wants 'every local authority to sign up to the government's pledge on making children's health a priority, and to publish and share good examples of what they are doing in their own areas.' He also spelled out that he expected local authorities to work in tandem with the NHS in addressing this issue. Our findings reveal that local authorities are broadly optimistic about the prospects for realising this vision. 72% of survey respondents expect to see increased integration/collaboration with children's service providers. Crucially, the director of children's services of a local authority is statutorily required to sit on HWBs, ensuring that the needs of local children are factored into the commissioning process.

27. Nicol, S. et al., *Quantifying the cost of poor housing* (BRE press, 2010)

28. www.ons.gov.uk/ons/rel/census/2011-census-analysis/a-century-of-home-ownership-and-renting-in-england-and-wales/short-story-on-housing.html

29. Figures taken from: DCLG, *Local authority housing statistics: 2011–12*, www.gov.uk/government/uploads/system/uploads/attachment_data/file/39457/Local_authority_housing_statistics_2011_12_v4.pdf (accessed 06/08/13)

30. www.gov.uk/government/policies/improving-the-rented-housing-sector–2/supporting-pages/private-rented-sector (accessed 06/08/13)

31. NICE, *Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation – NICE public health guidance 41* (Manchester, 2012) www.nice.org.uk/nicemedia/live/13975/61629/61629.pdf

32. Department for Transport, *Door to Door – A strategy for improving sustainable transport integration* (London, 2013), p.6

33. South Yorkshire Public Transport Executive, *South Yorkshire Public Transport Action Plan* (2011), p.11

Employment

There is a mass of evidence that being employed is a crucial determinant of a person's health and well-being. It has been demonstrated that being unemployed for significant periods of time can increase the risk of physical and mental ill-health.[34] But, despite a recent London Councils report that found locally-led employment schemes to be up to seven times more effective than the centrally organised Work Programme,[35] it remains firmly in the hands of central government. As the Commons CLG Committee comments, 'the priorities of the Department for Work and Pensions appear particularly resistant to the arguments for devolving power to local institutions'.[36]

Nonetheless, many local authorities are deeply involved in tackling worklessness in their area through a range of locally led and funded employment services. Examples include Kent County Council's long-running apprenticeships programme, which offers businesses grants of up to £2,000 to take on an unemployed 18–24 year old as an apprentice.[37]

Through these examples we have seen that restoring public health to the heart of local government requires fostering links and synergies with wider local government functions. But changing the behaviour of organisations that have developed over decades is never easy, and national political leadership on this issue could help break down barriers. **We therefore recommend the government consider making the Minister for Public Health a joint DoH/Cabinet Office position, in order to aid integration across departmental silos and make a statement that the Government is embedding public health at the heart of all its policies.**

Innovative approaches to public health

It is important to note that for the majority of those working in public health, these reforms do not represent wholesale change. The building in which they work may be different but much of what they do has not changed since April. The public health problems that they were working on last year are still there, and are still absorbing the overwhelming majority of public health budgets. Most JSNAs still place a real emphasis on 'traditional' public health themes such as smoking cessation, healthy eating, drugs, alcohol services and sexual health. For instance, of Blackburn and Darwen's £13 million total public health expenditure, only £1 million was set aside for tackling the wider social determinants of health. Of course, HWBs will want to be assured that existing public health approaches are demonstrably working, but where that is the case, it is to be expected that local authorities continue supporting such measures.

However, where identifiable local public health problems persist, it is entirely in the spirit of the reforms – in treating the causes rather than the symptoms of ill health – to look for innovative uses of the public health budget to tackle those causes. Wirral Borough Council, for example, has used some of the public health money to provide extra training for young drivers – a move it hopes will reduce road accidents. And Blackburn and Darwen has used some of the £1m noted above in a variety of novel ways, including providing debt advice and transferring some funds to services in other council departments 'that might otherwise face cuts, including falls prevention and leisure services'.[38]

Dr Stephen Watkins, director of public health at Stockport MBC and a member of the British Medical Association public health medicine committee, commenting on Blackburn's decision to spend money on falls prevention, said 'At first I raised some doubts about it but when I looked into it, it was done as a deliberate plan to maintain the independence of older people and avoid injuries. That's entirely

34. Institute of Health Equity, *The Big Opportunity – Part Two – Acting on the Wider Determinants of Health*, www.instituteofhealthequity.org/projects/acting-on-the-wider-determinants-of-health/the-big-opportinuty-acting-ont-he-wider-determinants-of-health.pdf (accessed 06/08/13), p.16

35. London Councils, *Getting London Working – A 10 point plan to improve employment provision* (London, 2013), p.11

36. CLG Committee, *The role of local authorities in health issues* (London, 2013), p.43

37. Kent County Council, *Kent Employment Programme grants*, www.kent.gov.uk/business/growing_your_business/grow_your_workforce/apprenticeships/kent_employment_programme.aspx (access 06/08/13)

38. HSJ, Councils' public health spending plans revealed, www.hsj.co.uk/news/councils-public-health-spending-plans-revealed/5059567.article (accessed 06/08/13)

legitimate.' However, he also cautioned that this approach should not be taken too far, emphasising that grant must be spent on policies that will improve the health of local residents.[39]

And there have been worries expressed that the ring-fence around the £2.7 billion public health budget transferred to local authority could prove a little leaky, especially given the increasing pressure on local government finances. When asked about how councils spent their public health grant' Public Health England chief executive Duncan Selbie observed that 'ultimately these are local decisions' though he went on to say that if money was spent on things 'completely outside any reasonable view about what constitutes health then of course we'd have to be addressing that'.[40]

Our research suggests that are no direct means by which the NHS might challenge local authority public health funding decisions. However, DsPH are required to issue an annual report outlining what they have spent public health funds on, and the impact that that spend has had. We therefore believe it is unlikely that local authorities will choose to divert money into things unrelated to health because they would need to defend such decisions to their opposition councillors, local media and residents. However, it is crucial that local authorities maintain public confidence in the reforms by **ensuring that they spend public health funds only on things that are demonstrably related to improving health outcomes for local people.**

Capturing performance metrics

In return for this freedom to innovate, it is vital that local authorities can prove to their local populations that the money is being spent on services that have resulted in demonstrably improved health outcomes. In order to do this, local authorities will need to put in place a system for measuring the impact of all their public health spend, including their more innovative investments, on local health outcomes. As one North London borough councillor put it, 'if you can't follow the money, you can't know whether you're getting value.'

Exactly how these outcomes are measured will be locally determined, with the 2012 Act, as we have seen, giving councils direct responsibility for the provision of health scrutiny functions.[41] HWBs are invited to agree on their own performance indicators for public health – relating not only to local but to national priorities. This approach was welcomed by the majority of our interviewees within both local government and public health. Asked whether they believe that the new strategy is underpinned by local performance metrics, 71% responded either 'Agree' or 'Strongly Agree'. A Home Counties DPH elaborated on the merits of a bottom-up approach: 'clear local targets, outcomes and ambitions that are smart and member-owned is far better than top down stuff.' Another DPH made the point that 'local targets make sense as priorities will vary across the country.' He pointed to the recent 'Longer Lives' publication from PH England, which 'clearly shows that councils face different challenges'. 'A generic set of targets,' therefore, 'can be unhelpful.'

Our interviews revealed a variety of different models for assessing public health outcomes. Kent, for example, has plans to develop a local outcomes framework for health and social care which sets the level of ambition for improvements in health and social care services and provides a measure against which the performance of all partners can be assessed.[42] One London Borough councillor explained how the HWB had set itself four public health priorities, each with its own specific targets, progress towards which will be assessed at regular intervals by the overview and scrutiny committee.

39. LGC, *Localism rises to the health challenge*, www.lgcplus.com/briefings/joint-working/health/localism-rises-to-the-health-challenge/5059293.article (accessed 06/08/13)

40. Ibid.

41. DH, *Local Authority Health Scrutiny*, www.consultations.dh.gov.uk/public-patient-engagement-experience/http-consultations-dh-gov-uk-ppe-local-authority (accessed 06/08/13)

42. Kent Health Commission, *Update Report* (accessed 29/04/13)

Despite the different approaches, there was absolute consensus that, to avoid profligacy and maximise value for money, all public health spend must be rigorously accountable. **It is vital therefore that all councils have in place robust mechanisms to measure the impacts of their public health spending decisions.** Equally it is crucial that all local authorities have a strong and robust health scrutiny function. **We therefore recommend that local authorities provide their health scrutiny committees with the appropriate support to enable them to perform their duties properly.** This support is particularly important given both the technical elements of health and the fact that health will be new to many in local government.

The role of local authorities in integrating health and social care

For decades, closer integration of health and social care has been the holy grail of health policy. Despite this, as Sheffield's CCG recently reported in its attempt to merge substantial elements of the health and social care budgets, many of the 'technological, contractual, governance and financial' barriers to joined-up care remain. This Government's ambition – to make joined-up and coordinated health and social care the norm by 2018 – is therefore a continuation of this theme, but this time backed by stronger financial drivers.

There is now cross party agreement on the fact that local authorities will have to play a pivotal role in forging this closer engagement. HWBs have been given a substantial mandate to encourage integrated working between the NHS, public health and social care services. But how far will this mandate go? Minister for Care, Norman Lamb MP, has recently launched plans to join-up health and social care through pioneer areas, with the first cohort due to be announced in autumn 2013. Shadow Health Secretary Andy Burnham MP meanwhile, has proposed plans for yet closer integration at a local level which would see HWBs become the main commissioning bodies within the NHS.

Whichever road is taken, for integration to take root requires local government itself to assume an active, leading role. There a number of related mechanisms for realising this goal – including pooled budgets and community budgets.

Pooled budgets

A pooled budget is a mechanism by which partners bring money to form a discrete fund, to achieve specific outcomes, with partners sharing in any savings of efficiencies generated.[43] The Health and Social Care Act encourages local authorities and their NHS partners to pool or align budgets: £3.8 billion of NHS money is locally allocated to support the integration of health and social care over the next four years, offering a real impetus for sharing resources.

There is a growing recognition of the merits of this more integrated approach to commissioning. In Oxfordshire, for example, where the PCT and County Council had held pooled commissioning budgets covering Older People and Physical Disability, Learning Disability and Mental Health since 2006 (which ended on 31 March 2013), the CCG is building on existing arrangements to ensure even greater integration of health and social care, so delivering the best use of resources and improved health outcomes. And Oxfordshire County Council has recently agreed to a set of changes which will see the shared older people's services budget nearly double from £108m to £195m. Kent County Council have made similarly positive noises, pledging to 'show how integrated commissioning, pooled budgets and integrated health and social care services providing co-ordinated care can bring about a transformation in health and social care leading to better patient care and outcomes.'

43. DCLG, *Guidance to local areas in England on pooling and aligning budgets* (London, 2010), p.8

Despite such cases, and a growing recognition reflected in our interviews that pooling resources can deliver better outcomes and value for money for local people, Smith Institute research shows that even in 2012 they only represent less than 5% of total NHS and social care expenditure.[44] **We therefore suggest that local authorities work to maximise opportunities to pool budgets between council departments and health spend.**

Our interviews also revealed a tendency towards aligning rather than pooling health and public health budgets (i.e. partners jointly considering their budgets and agreeing on aims and outcomes but without agreeing to share funding). While local partners were happy to align budgets based on shared outcomes, objectives and strategies, those unwilling to take the next step to pooling budgets cited a lack of capacity to design appropriately detailed agreements on issues such as accountability, management of risks and an exit strategy as the major inhibitors. We hope that the Government/LGA sponsored Commissioning Academy opened in April can help the sector to address these skills shortages.[45]

Community budgets

Community budgets (CB) is a programme of enhanced pooled budgets operating across the public sector in specific geographic areas, designed to give local public sector partners the freedom to work together to redesign services around the needs of citizens, with the goal of improving outcomes for residents and eliminating duplication of effort. There are four 'whole place' CB pilots testing a number of specific business cases across a range of policy areas from work and skills to reducing reoffending to health and social care integration. The Government has been explicit in saying that the forthcoming integration pioneers programme will build on the learning of the CB pilots. **We therefore urge the Government to continue to promote the learning of the Community Budget pilots to all local authorities in the country.**

Working in partnership with non-traditional providers

Competition and choice were two of the key drivers behind the Health and Social Care Act. In theory, by devolving commissioning to a more local level and opening up the provision of services to 'any qualified provider',[46] the health reforms enable providers from the NHS, private sector and voluntary sector to compete on a level playing field.

And our research revealed a real appetite among local authorities for the freedom to choose providers. One council leader described the frustration he had felt at an inability to decommission a contract with a community health trust which he felt had been 'running the same old tired services for years'. For him and many others, entry into a free and open market represents a 'dramatically exciting' opportunity to improve health services. While the outsourcing of health and public health services through commissioning is contentious, public attitudes, too, are clear: a survey carried out by Populus in 2012 found that 75% of respondents did not mind who provided public services as long as those services were high quality and free.

In all cases, we agree with the government that a service should be delivered by the supplier best placed to deliver it, irrespective of sector. **We therefore strongly urge the government to maintain its position that strategic commissioning must be 'provider neutral', focusing on local need and the best pathways to deliver services to meet that need.**

44. The Smith Institute (ed.), *Getting started: prospects for health and wellbeing boards* (London, 2012), p.20 www.smith-institute.org.uk/file/Health%20and%20Well%20Being%20Boards.pdf

45. Cabinet Office, *Trailblazing academy to help transform public sector services*, www.gov.uk/government/news/trailblazing-academy-to-help-transform-public-sector-services (accessed 06/08/13)

46. HSJ, *What happened to 'any qualified provider?*, www.hsj.co.uk/opinion/what-happened-to-any-qualified-provider/5057428.article (assessed 6/08/2013)

Appendix: Survey results

1. How prepared is your local authority to commission public health services? [On a scale of 1–10, 1 being very unprepared and 10 being very well prepared]

1	2	3	4	5	6	7	8	9	10	Rating average	Rating count
1.3% (1)	0.0% (0)	5.0% (4)	3.8% (3)	6.3% (5)	5.0% (4)	17.5% (14)	22.5% (18)	21.3% (17)	17.5% (14)	7.61	80
								Answered question			80
								Skipped question			0

2. How prepared is your local authority to work with a range of partners? [On a scale of 1-10, 1 being very unprepared and 10 being very well prepared]

	1	2	3	4	5	6	7	8	9	10	Rating count
NHS commissioners	0.0% (0)	1.3% (1)	1.3% (1)	0.0% (0)	3.8% (3)	8.8% (7)	13.8% (11)	18.8% (15)	31.3% (25)	21.3% (17)	80
Third & voluntary sector	0.0% (0)	0.0% (0)	1.3% (1)	0.0% (0)	2.6% (2)	7.7% (6)	11.5% (9)	29.5% (23)	25.6% (20)	21.8% (17)	78
Local health providers	0.0% (0)	0.0% (0)	0.0% (0)	3.8% (3)	2.5% (2)	7.6% (6)	11.4% (9)	29.1% (23)	26.6% (21)	19.0% (15)	79
New potential providers more generally	0.0% (0)	3.8% (3)	1.3% (1)	2.5% (2)	22.8% (18)	15.2% (12)	16.5% (13)	20.3% (16)	10.1% (8)	7.6% (6)	79
								Answered question			80
								Skipped question			0

3. Do you believe that your local authority will be able to positively influence the public health of your residents?

Answer options	Response percent	Response count
Yes, immediately	33.8%	27
Yes, eventually	62.5%	50
Probably not	0.0%	0
Definitely not	1.3%	1
Too early to say	2.5%	2
	Answered question	80
	Skipped question	0

4. What benefits do you hope/anticipate that the involvement of local government will offer to the provision of health/services in your area?

Answer options	Response percent	Response count
Better use of data	50.0%	40
More joined up service provision	90.0%	72
Greater efficiency	67.5%	54
Enhanced place shaping	50.0%	40
Democratic accountability	63.8%	51
More patient driven	46.3%	37
	Other [open ended comments]	7
	Answered question	80
	Skipped question	0

5. Will health and wellbeing boards effectively influence the delivery of improved health outcomes in your area?

Answer options	Response percent	Response count
Yes, immediately	21.3%	17
Yes, eventually	62.5%	50
Probably not	5.0%	4
Definitely not	1.3%	1
Too early to say	10.0%	8
	Answered question	80
	Skipped question	0

6. Will health and wellbeing boards need more powers to influence NHS commissioners?

Answer options	Response percent	Response count
Yes, certainly	21.3%	17
Yes, probably	41.3%	33
Probably not	12.5%	10
Definitely not	1.3%	1
Too early to say	23.8%	19
If so, what other powers do you think might be needed? [open ended comments]		18
	Answered question	80
	Skipped question	0

7. How much do you agree with the following statement – 'The local Joint Strategic Needs Assessment has informed the local health and wellbeing strategy?'

Answer options	Response percent	Response count
Strongly agree	41.3%	33
Agree	43.8%	35
Undecided	10.0%	8
Disagree	2.5%	2
Strongly disagree	2.5%	2
What could be done to improve them? [open ended comments]		12
	Answered question	80
	Skipped question	0

8. How much do you agree with the following statement – 'The local health and wellbeing strategy is underpinned by local performance metrics'?

Answer options	Response percent	Response count
Strongly agree	20.0%	16
Agree	52.5%	42
Undecided	21.3%	17
Disagree	6.3%	5
Strongly disagree	0.0%	0
	Answered question	80
	Skipped question	0

9. In terms of the data/evidence available locally, would you say that there is:

Answer options	Response percent	Response count
Too much data	3.8%	3
Broadly the right amount of data	37.5%	30
Broadly the right amount, but not enough analysis of that data	38.8%	31
Not enough data	3.8%	3
Not enough useful data	12.5%	10
Don't know	3.8%	3
	Answered question	80
	Skipped question	0

10. Will the new health landscape stimulate a shift towards increased investment in primary and secondary prevention?

Answer options	Response percent	Response count
More likely	63.8%	51
Less likely	10.0%	8
Equally likely	26.3%	21
	Answered question	80
	Skipped question	0

11. Which other local authority services do you believe will see increased integration / collaboration with public health services in particular?

Answer options	Response percent	Response count
Housing	76.3%	61
Transport	32.5%	26
Children's services	72.5%	58
Adult social care	87.5%	70
Planning	36.3%	29
	Other [open ended comments]	12
	Answered question	80
	Skipped question	0

12. How culturally different is local government compared to your new health partners? [On a scale of 1–10, 1 being totally alien and 10 virtually the same]

1	2	3	4	5	6	7	8	9	10	Rating average	Rating count
1.3% (1)	7.5% (6)	20.0% (16)	12.5% (10)	21.3% (17)	17.5% (14)	7.5% (6)	10.0% (8)	2.5% (2)	0.0% (0)	4.93	80
								Answered question			80
								Skipped question			0

I warmly welcome this timely study of the implications of greater engagement between local government and the full range of health and care services. The progressive divorce between locally determined care services and nationally directed public health and acute health services was always a policy dead-end. Gwilym Tudor Jones encourages both national and local government to think about the implications of putting this great historical error into reverse.
Rt Hon Stephen Dorrell MP, Chair of the Health Select Committee and former Secretary of State for Health

The return of public health to local government is a welcome development that offers the potential for significant benefits. To secure improvements, however, local councils will have to work hard to engage not only with their local NHS, but with other areas such as employment, housing and transport. To that end this report offers useful recommendations on collaboration between health and wellbeing boards and clinical commissioning groups, on holding GPs and NHS England to account and on how councils can embed public health in all local services. These are the first steps in tackling the causes of the causes of poor health.
Clive Betts MP, Chair of the Communities and Local Government Select Committee

The biggest single challenge facing the public sector at the moment is coping with the demands of the UK's ageing population. Drawing together services at a local level to promote healthy lifestyles and collaborate in a way which enables people to stay independent longer and reduces the need for acute treatments is fundamental to meeting that challenge. The shift toward greater local control of health commissioning and provision through the leadership of health and wellbeing boards points the way to a better way of working, but this type of approach has to be embraced right across the public sector. The LGA is working with national partners and local authorities to support all areas to develop strong and integrated plans that address local health challenges and make the most of local assets. Localis has yet again provided a considered and thought-provoking analysis which will no doubt help the sector to work to place greater control over services into the hands of local communities.
Cllr Sir Merrick Cockell, Chairman of the Local Government Association

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