“Local Government is a Public Health Organisation”
Facilitated by Phil Swann, Programme Director, Shared Intelligence

“The origins of our public health system lie in the response of local government to the cholera outbreak of the 1840s. Civic leaders, including business, the church, and typically the local press, became involved in mobilising local assets and resources for sanitary reform. Water, sewers, paved streets and refuse collection were followed by a focus on housing and town planning. The success of local government in defending the health of its citizens not only led to enhanced legal and fundraising powers but to enhanced credibility. Over time the range of local government provided services became formidable – and so successful were local authorities in providing direct services that many have come to think that that is the core business of local government losing sight of its role in providing leadership and mobilising and enabling communities. This workstream considered how best local government can promote the health and wellbeing of its citizens through innovative commissioning of seamless health and social care services”.

Speakers:
Caroline Tapster  Chief Executive, Hertfordshire County Council
Tony Hunter  Chief Executive, North East Lincolnshire Council
Ciarán Devane  Chief Executive, Macmillan Cancer Support
Professor Phil Hanlon  Professor of Public Health, Glasgow University
Sally Gainsbury  Financial Times Reporter & Health Service Journal Columnist
Dr Kate Ardern  Executive Director of Public Health
Saffron Cordery  Director of Communications and Strategy, The Foundation Trust Network
Dr David Paynton  GP, National Clinical Champion, Royal College of General Practitioners Centre for Commissioning
Paul Lankester  Chief Executive, Stratford upon Avon Council

Session 1: What are the public health priorities and challenges facing local communities?

This session sought to examine the following questions:

- What are the public health challenges facing the country and local communities today?
- How does public health relate to the changing NHS landscape?
- What is the need in relation to, for example, dealing with long term conditions?

Contributions:
A co-ordinated, holistic and ‘whole-systems’ approach to public health is essential if we are to overcome: the multiple cross-organisational cultural difficulties in working with different partner organisations; the behavioural challenges of both organisations and individual members of the public (e.g. how can we help individuals to become more responsible for
their health?); and the inherent difficulties in effectively measuring performance (e.g. how can we effectively measure health outcomes over long periods of time?)

**Caroline Tapster, Chief Executive, Hertfordshire County Council**

We have to change the way health services are delivered; fundamental reconfiguration is absolutely necessary. Local Government will have to have a new leadership role. A key issue currently is that health problems are split into components; we need to develop a broader approach that takes into consideration wider social ‘people’ problems and not just medical conditions. The critical question is whether the challenges we face make reconfiguration better; will we get the ‘holy grail’ of prevention that we’re looking for?

**Tony Hunter, Chief Executive, North East Lincolnshire Council**

There are lots of actions but no one knows how to undertake implementation so there is genuine long-term impact. We are overwhelmed by structures, funding transfers and staff-related issues.

**Paul Lankester, Chief Executive, Startford-upon-Avon District Council**

The main reason for local government is to improve the quality of life of the population. Some of the challenges we face are as follows:

- Delivering outcomes longer than political cycles; outcomes are often well outside of political cycles.
- There is a risk of scarce resources in a county structure;
- Problems with data consolidation, evidence and profiles;
- The need for a ‘whole systems’ approach to health and wellbeing (we normally talk about ‘treatment’ but have a role to look at health more holistically);
- Looking after older people.

**Saffron Crodery, Director of Communications and Strategy, The Foundation Trust Network**

The impact of the Health and Social Care Bill:

- Takes further the commissioner / provider split;
- Changes the nature of relationships across the system and ‘fuzzes’ the boundaries;
- Dismantles old structures and performance management-led approaches;
- Abolishes NHS Trusts and local involvement networks;
- Creates a new regional infrastructure by developing big ‘mega’ regions;
- Creates Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards (HWBs), Local Health Watch etc.

What are the challenges we face:

- Money around relationships and accountability - £20bn in NHS finances – money management is critical;
- Commissioner-provider relationships will be critical, as will relationships between HWBs and commissioning groups;
– We will need to develop a common understanding of what ‘accountability’ means;
– Making localism a reality;
– Looking at duplications in local accountability;
– Do reforms support the Total Place approach or undermine it?

Ciaran Devane, Chief Executive, Macmillan Cancer Support

The NHS is not an inefficient system, although there are inefficiencies. There are good things within the Bill, for example the focus on outcomes and encouraging principles such as ‘no decision about me without me’. However, the public health challenges facing communities is increasing – we have an aging population and there are 3.5 million people with cancer who are in not in hospital. These 3.5 million people are the concern of Local Authorities and social care.

In order to keep people well in general, as opposed to treating specific medical conditions, there are three fundamental things we need to do differently. Firstly, we need a whole systems change. This is not about different budgets; we need an integrated population approach. Second, we need to consider how workforce dynamics will change if we keep people well at home, i.e. what does this mean for nursing skills? Third, we need to encourage personalisation and self-management.

Going forward, we need to do more of what works, build community-based services, and develop a whole-systems approach. There is also a point to be made about addressing the ‘teachable moments’. We need to encourage a different approach; e.g. instead of commissioning for every cancer patient to see a doctor, why do we not work with the local authority, gyms etc. and take a different approach.

Discussion: What are the challenges we face?

Group feedback:
– We need to mainstream / upstream spending. We need to make sense of both the NHS and the social care system – both of which have dysfunctional effects and are conflicting.
– We need to develop common priorities and mechanisms for delivering these, with an increased focus on measuring outcomes – a whole-systems approach.
– Relationships are critical and we need to take time to invest in relationships between different organisations.
– Localities are also important and add complexity – different health issues are more prevalent in certain areas. There are also fuzzy geographical boundaries and related data issues to be addressed.
– We need to maximise the ‘teachable’ moments – work with people early at the right time so they are encouraged to take control of their own destiny.
– There is fragmentation of systems and processes which need to be clarified.
– Commissioners need to understand what really works and what things cost in order to drive the system.
Local government needs to shape the agenda – we want people to change their attitudes and behaviour and have the ability to articulate within their populations why this is important.

**General discussion:**
- Outcomes take a long time to materialise which has issues for performance management and accountability
- Behaviour change – we need to find the right buttons to influence behaviour.
- There is an issue around a lack of knowledge of costs, particularly within the NHS.
- How do we achieve real engagement and get patients’ views into the room?
- How do existing networks fit into emerging ones?
- How are we going to realise our ambitions for a highly complex system in the tight timescales available?
- Organisations need to learn to be accountable for effects they cannot necessarily control.
- We need cultural change in local government to enable the development of an alliance between local councils and GPs with the shared ambition of making things better for communities.
- We need to move away from top-down performance management systems to ‘local anarchy’ in order to provide a way for innovation with scarce resources.
- Organisations that take on community services need to change the way they function – are there lessons we can learn from this interface which can be transferred?
- We need to work with multiple partners to develop a clear understanding of everything local government needs to ‘upstream’ and ‘downstream’.
- We need a “coalition of the willing” and courage to go with intuition, maximising flexibility, creativity and innovation along the way.

**Sally Gainsbury, FT Journalist and “critical friend”**

Local authorities are going to the table with £2 billion out of £105 billion. How do they leverage with that and what other powers do they have? It is a big challenge for hospitals to be incentivised by outcomes – traditionally they have been financially motivated. We must also bear in mind that hospitals have a lot of influence over people’s perceptions.

**Concluding remarks:**

“We must look at the individual as an individual, not as a specific condition – there has to be something in that”.

The discussion ended with a general consensus that the challenges around local government as a public health organisation need to be addressed holistically, with multiple partners, perhaps through a ‘cultural alliance’.
Session 2: What is the potential scope of the public health offer?

This session sought to examine the following questions:

- What is the potential scope of the public health offer?
- How does it relate to the other functions of councils and their partners?
- What does locating this function in local government mean for public health and for councils?
- Is it a big deal?
- Is the integrity of public health worth the potential fragmentation nationally?
- What is the public health role?

Aspects of public health where there is uncertainty and aspects of the public health role that need to be developed:

- How does public health fit into the current local government structure?
- What does the wellbeing agenda add to public health and how can we conceptualise the term?
- Governance is muddled, inconsistent and there is a lack of consensus.
- Need to develop how governance will be enforced.
- Resource incentives – there are perverse incentives in the way commissioning operates.
- How can we get integration across all organisations

What is the public health role?

Dr Kate Ardern, Executive Director of Public Health

We need to work towards a broader wellbeing agenda whereby the Local government agenda is intertwined with the NHS programme.

CASE STUDY: TOBACCO – The NHS measure is the number of four week quitters but will this really improve health and wellbeing. There are wider issues within the community, for example illicit tobacco dens. We need to work with the community and seize this opportunity to collate organisational intelligence and work with local people. Wigan Smoke Free initiative is an example of cross-organisational working and sharing collective intelligence which resulted in multiple benefits: police solved crimes, Trading Standards enforced regulation, the local community was involved in resolving anti-social behaviour and the NHS ‘take out’ a major supplier. Working collaboratively raises the opportunity to tackle the root causes of public health problems.

Of course, our ability to seize on such opportunities is dependent on a variety of factors, including: the quality of individual personal relationships and cultural change (intertwining the whole workforce and encouraging them to think about health and wellbeing). Skills development and passing on expertise is also critical. Wigan are running a public health capacity building programme focusing on training call centre staff to direct people to the right area. But developing skills also needs to take place in our communities and in our schools. We need to build community resilience and capacity and empower the community to take charge of their own health, which involves taking a longer-term view.
We will always need specialisms in public health but in terms of health improvement, we can work cross-organisationally using HWBs at local levels as the ‘ring holders’.

Some of the challenges we face include:

– Competing cultures: Whitehall wanting to hold onto things verses localism
– Most Directors of Public Health have grown up in the NHS. To be strategic leaders they must rise to the challenge, be credible, be technical experts and remain strategic.

The key messages: 1. to see the NHS as a resource and not a nuisance, 2. not to be put off by the personalities of incumbents, 3. Think about what local government needs from Directors of Public Health and try to get beyond who is in the role.

“We need to empower the local community to help people take change of their own health too”.

Tony Hunter, Chief Executive, North East Lincolnshire Council

Our work has been focused on challenging specialisms and encouraging a broader approach. How can we hold this agenda locally? How can we develop access with GPs? How can we be ‘leaders of place’?

What do Chief Executives need to think about?

– Promoting self-advocacy for people enabling them to develop their own lives as they want.
– Contribute to the ‘feel good’ wellbeing factor.
– Ensure the whole organisation is engaged in the wider issue of wellbeing so that we do not have a narrowly defined public health function.
– Mediate and provide space for a local solution and allow commissioning groups to ‘win’ in an NHS context.
– Help the Director of Public Health to become part of the corporate management team with a much broader brief that goes beyond specific health conditions.
– Foster financial confidence in the short-term.
– Understand what PCTs are doing.
– Demonstrate commissioning competence.
– Engage with trade unions so that resources are used differently.

Sally Gainsbury, FT Journalist and “critical friend”

Is there an opportunity for councils to audit everything and embed health and wellbeing into all services? This may be a way of developing a bigger ‘negotiation’ chip. What is the definition of wellbeing? In the NHS, wellbeing is about quality-adjusted life. Conversations need to be had with the NHS very early on.
Session 3: What are the conditions for effectiveness?

This session sought to examine the following questions:

- How do local councils need to organise themselves – internally and in collaboration with others?
- What are the links with the NHS and how should they work?
- What is the role of Health and Wellbeing Boards?
- How will central-local tensions play out?
- What are the leadership challenges?
- Is local government ‘up for’ this agenda?
- Is it possible to reconcile the different cultures of all the organisations involved?
- How does local government need to change in order to commit to its new function / role?

David Paynton, GP and Director of PCT

There are some key questions which need to be addressed:

1. Is local government up for this agenda or do they see it as the domain of health?
2. Do we recognise the difference between commissioning for health and wellbeing, which requires a long-term strategy, and commissioning for health care?
3. Do we know what is new this time or is it just PCTs being reinvented? In the past, pathways have been driven by what providers want to do, generating activity and outcome. We need to move away from PCT activity-based contracting to outcome-based commissioning but to do this we need to be clear what are the clinical outcomes needed? (Reference the NICE National Outcomes Framework for advice, which local authorities have an opportunity to contribute to).

What are the challenges we face?

- Shared Leadership – local authorities need to work with Clinical Commissioning Groups (CCGs) locally to develop shared vision and leadership, and to then be accountable.
- Culture – between organisations but also more broadly – we need to see a shift in healthcare away from hospitals and back into the community,
- Timescales – this agenda requires a long-term approach.
- There will be less top-down, detailed and imposing instructions.
- Trust in partnerships – cash will only be released where there is trust. We need to work with local GPs and commissioning groups to establish mutual partnerships. This takes time.

Caroline Tapster, Chief Executive, Hertfordshire Council

Building relationships, networks and engagement – how can we get into the mindsets of other organisations? Some public health colleagues are fearful of working in more political environments. We need to get to grips with the ‘network’ and undertake a mapping exercise
to better understand how we can do effective networking. We need to balance networks with engagement understanding how we differentiate HWBs from other local government bodies. It is also about wider engagement with communities, health scrutiny bodies, elected members, NHS patient groups, GP patient reference groups and so on. If we are to make this transformation successful we need to understand how the different determinants can work together in a holistic way.

**Providing support** – We need to support one another through a ‘local coalition’ so we are able to resist centralising influences. Local authorities need to think about how they can support HWBs, for example through meeting the personal induction needs of staff. Thinking more widely, we will need to focus support on carers to that more people can be looked after at home rather than in nursing care.

**Developing a strong evidence base** – We need a stronger evidence-based approach to wellbeing. Hertfordshire Council has been investing in ‘happiness’ lessons in schools for years and it works.

Paul Lankester, Chief Executive, Stratford upon Avon Council

Local authorities must stop asking for guidance from central government; central government doesn’t understand two-tier. Local government needs to change its culture and recognise that professionals don’t always know best. We might have to learn a new language – ‘NHS speak’. Perhaps we can find a more simple terminology that everyone can understand? Innovation and flexibility is vital. Are new structures like HWBs and LEPs sucking out innovation? We need clear data on health and wellbeing areas to fuel discussions with members and to enable us to prioritise key areas. Local authorities need the maturity to give up sovereignty and invest in well-researched models, whether they utilise voluntary sector organisations, the private sector or the public sector.

**Discussion:**

- Surely there is a balance when it comes to trusting professionals?
- Does introducing public health to a more political environment provide an opportunity for real visibility?
- The real test for a Chief Executive is how to moderate the debate to ensure it is outcomes focused and does not become party political as this can corrupt the conversation.
- Would it be beneficial to have a public health agency?

**What steps do local authorities need to take next?**

- Continue to develop strong working relationships with health teams.
- Think about the community more broadly and flexibly and focus on wider solutions.
- Better integrate budgets.
- The ‘health bureaucracy’ is much less interested in working with local authorities than GPs. Don’t miss the ‘big prize’ – integration.
- Support commissioning groups in practical ways where possible, e.g. by offering office space and financial advice.
- Invest in a ‘knowledge upgrade’ so we have a clear understanding of what the structures are, what is happening in health and what opportunities exist.
– Ensure all groups have a shared data understanding – the data exists but is it being brought together and being used by the right people?
– Engage in effective life planning
– Provide coaching for delivery in a smaller environment
– Collate and share evidence of what is going on and what works.
– Pay more attention to data.
– Articulate what success looks like regarding the collaboration of local authorities and GPs.
– Understand what’s in this agenda for health.
– Understand how you make local accountability real and what accountability means.
– In 2013 the tariff will be split into the acute phase and the re-enablement phase. This presents an opportunity for local authorities to configure that enablement to ensure, for example, an elderly person is less likely to end up in a nursing home.

Sally Gainsbury, FT Journalist and “critical friend”

Local government is further on than the NHS in terms of outcomes. Sceptical that CCGs will be easy to engage with; we will probably find they have few GPs on them. Make sure the quality of primary care is on the table.

Session 4: What is our offer?

This session will draw the various strands together and focus on next steps.

Professor Phil Hanlon, Professor of Public Health, Glasgow University

What are we trying to do?

In 1830, in any city, we would find people pouring into industrial centres and the life expectancy would be around 35 years old. How have we more than doubled life expectancy and expanded quality of life? The first thing our civic ‘fathers’ did was to create order, i.e. take sewage out of water. The process was top-down (‘Peelers’) and bottom-up (people patrolling the streets). The priority was to bring order out of disorder. By 1860, a lot of work had been done but life expectancy remained around 35 years of age. Prosperity was a key factor in bringing significant health improvements, and this remains true today. A modern-day reduction in prosperity is a real threat.

Today we have the appliance of science in many different spheres (commerce, industry, health etc.) and the task of using evidence of what works to improve the quality of life. In the past, the application of science in all aspects of live brought about the greatest improvements. This is a fundamental function of public health. Evidence-based application is a more complex challenge than it has been previously. We have to ask are local authorities good environments for academic enquiry?

The welfare state and the ‘cradle to grave’ vision is one of diminishing returns. The solving of this problem is the biggest health problem. The biggest improvement in public health has been around medical improvements for the elderly.
Our challenge today is to bring order, prosperity, evidence, equity, good care, and quality services in an effective way to our communities at a good cost. Yet there are a whole series of problems: city epidemics; inequalities; mental health disorders; loss of wellbeing; addictive disorders. These things are products of the way we live our lives. So we need bottom-up and top-down processes within an environment where new ideas can flourish. A new set of problems needs a new way. Modernity is moving into crisis, something new is required in order to change itself.

What is local government’s offer? What can we bring to the challenges inherent in this agenda?

Local government has a unique place for the collective and the community. This is crucial and enables councils to play a core role in bringing stakeholders together to provide solutions.

“A new level of invention and innovation is needed to confront new public health challenges which are currently on escalating trends”

“Creating environments where ideas, innovation and science can flourish are vital to improving public health”

“Individual service interventions make very little impact, the whole environment matters in public health”

“We have to create a sense of security that you can still keep the lights on while having the boldness to move forward”

“We have to engineer something different”

“We need to be midwives of the new and undertakers of the old”

Further discussion points:

- Innovation needs to happen in partnerships as parties come together.
- “You cannot solve a problem with a conscience that created it”.
- Is politics a problem? – yesterday’s problems were about necessity whereas today’s are more about choice.
- Is there consensus that if we do nothing we will spiral downward? It is only when people recognise the problems that things may happen.
- There is no coherent transformation ‘movement’ but pockets of change everywhere.
- How can we get beyond vested interests?
- How can we change individual behaviour?
- What can we do to enable people to make better-informed life choices?
- We need a stronger emphasis on those who are disadvantaged.
- We need to make health integral to organisations and communities.
- The whole environment matters.
- We need to be radical in honesty with staff to bring about transition.