REACHING OUT
INFLUENCING THE WIDER DETERMINANTS OF HEALTH

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

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ACKNOWLEDGEMENTS

FOREWORD

Local government is at the forefront of improving health and wellbeing. Since responsibility for public health transferred in 2013, councils have responded with innovation and collaboration and this report sets many of the exciting new approaches that have been developed.

The health and care landscape is transforming. Local Sustainability and Transformation Plans recognise that we will only succeed as a system, if we get prevention right.

The challenges of an ageing population, widening health inequalities and a backdrop of falling budgets mean that effective prevention has never been more essential. Investing in effective prevention at the same time as responding to rising demand requires skilful leadership.

It also requires a change in the way that we work with the public. Exciting developments in technology offer new ways to engage with people and support them to lead healthier lives. Partnership working with health colleagues is opening up new developments such as social prescribing, drawing in our rich voluntary sector and community resources, to enable GPs to offer a range of solutions to challenges such as social isolation. We are working together to encourage and motivate behaviours that reduce or manage clinical conditions such as diabetes and cardiovascular disease. In Kent, for example, we have embraced the national ONE YOU campaign with the creation of ONE YOU Kent. This brings together local authority communication channels, and Kent County Council, district council and NHS resources, to offer an integrated lifestyle approach that moves away from a traditional clinical service-based response.

Collaboration is crucial. In two-tier areas, county councils hold public health responsibilities, but district councils are key partners, given their levers for planning, environmental health and housing, and of course, their relationships with local communities.

In these challenging times, council leadership will utilise every opportunity at its disposal to improve health and wellbeing. The public health workforce brings an important skillset particularly on data analytics, to enable us to invest in solutions or services that will have the greatest impact.

In Kent, we are putting public health at the heart of our new commissioning arrangements. This will ensure that our decisions are based on the rich data in needs assessments and our developing integrated data sets. This report reminds us of the value of using the evidence-based approach that is central to public health, and the opportunity that this brings when working in partnership. We will have the greatest impact bringing this together with our children's and adult services, alongside our infrastructure to influence economic growth and the environment.

We are still at the early stages of the transition to local government but the case studies in this report show that we are already seeing significant positive impact from the change. In Kent, we are proud that despite budget reductions in the Public Health Grant, we have seen a 24 per cent increase in the number of developmental reviews delivered for all families by health visitors, with children under 5. It is these kind of improvements that as councils we can deliver for families.

Clearly, this report welcomes the progress to date. But it also sets out that we must be ambitious to do more, urgently. We must extend our influence to shape the wider determinants, creating healthy places and healthy communities for all. Local government has the potential to seize this opportunity and I encourage you to read this report to drive the efforts in your local communities to do this.

CLLR PAUL CARTER CBE
Leader, Kent County Council

EXECUTIVE SUMMARY

The 2013 transfer of public health to local government was an opportunity to address the wider determinants of health; to shape some of the broadest factors that affect the health of the population over the life course, such as where we live and where we work. This report focuses on the different ways in which public health in local government is influencing the wider determinants of health, what the challenges are, and where there is potential to go further.

The methods we used to complete the report included desk-based research; three surveys of elected members, officers and directors of public health (DsPH); case study visits of three councils, in-depth interviews, and two roundtables.

PROGRESS SINCE 2013

Over 85 per cent of non-public health officers that we surveyed agreed that public health had engaged with other departments in their council. Looking at this in more detail, people-focused departments such as children's services and adult social care were the most engaged with public health, according to DsPH respondents. Our research revealed many examples of joint actions which have emerged as a result of engagement with other council departments, in areas such as cycling initiatives, weight reduction, tobacco control, healthy eating and education, domestic abuse, open space and parks, and homelessness reduction.

Externally, over 92 per cent of public health respondents said they are collaborating with the voluntary and community sectors. The strong relationship between public health and the voluntary sector has, in some areas, helped to develop social capital in communities and improve mental health.

NEW RELATIONSHIPS FOR PUBLIC HEALTH

A stable, good quality job, decent home and thriving community strongly determine someone's health over a lifetime, and their children's health from before they are born.[1] And so, to strengthen the preventative offer, the influence of public health will need to extend to a wider range of services which can help reduce illness before it ever occurs.

For example, the local economy, and access to good quality work, is a major determinant of health. But those responsible for economic development within councils were among the council departments least engaged with the public health remit. Our survey shows that only 12.8 per cent of DsPH respondents felt that economic development departments were very engaged. And externally, public health teams were also less likely to engage with employers. Only 4.9 per cent of Health and Wellbeing Boards (HWBs) have representation from employers.

In two tier areas, district councils hold some key levers to address the wider determinants, such as housing and planning. Yet there were opportunities to strengthen engagement. For example, our survey showed that district council officers were comparatively unlikely to have been involved in the creation of the Joint Strategic Needs Assessment (JSNA).[2] The JSNA is a key document to understand the local population's health needs and strategic responses to this. It is important that district councils' unique insight into their population is captured.

Our findings also suggest there is an opportunity to develop stronger relationships with organisations working with marginalised groups who experience some of the worst health outcomes – in particular, local criminal justice agencies. Probation services were rarely represented on HWBs (9.9 per cent of survey respondents) and neither were prisons

[1] Marmot, M. et al (2010). Fair society, healthy lives: Strategic review of health inequalities in England post-2010. The Marmot Review Team.
[2] 31.8 per cent of district council officers said the public health team had engaged with them through creation of the JSNA compared to 54.97 per cent of all non-public health council officers.

(zero per cent of survey respondents). Working with these services could have a positive effect on the health of offenders, and also the communities they come from.

STRENGTHENING THE IMPACT OF PUBLIC HEALTH: SKILLS

Key to extending the reach of public health will be a workforce with the skills to engage, influence and persuade. Almost all of the DsPH (93.7 per cent) we surveyed agreed that since the transfer, their workforce needs different skillsets with 'communication and influencing' and 'storytelling with data' as the top skills identified as being needed more.

The need for public health teams to adjust to working in a different environment has been widely noted in reviews of the transition over to local government.[3] While many now feel positive about sitting within local government and are adapting, there is still a development need for the soft skills to engage and persuade local place leaders, including but not limited to elected members. Some DsPH have developed particularly strong strategies in communication and influencing, with scope to formalize this into a peer-to-peer training programme.

STRENGTHENING THE IMPACT OF PUBLIC HEALTH: FINANCES

The finances of local government overall and public health teams specifically are reducing. Initially, the transfer of public health to local government was accompanied by a ringfenced grant. But in-year, and then year-on-year cuts are eventually morphing into the complete removal of the funding ring-fence by 2019. Locally, public health teams are maximising their resources to best effect through targeting their resources where the need is greatest and finding ways to generate income. For example, one of the ways they are generating income is through commercialization (54.7

[3] The change in official status was noted as a potential challenge in House of Commons Select Committee (2013). Public Health post 2013

per cent of DsPH said they were doing this). Survey respondents said they were selling services and products such as health informatics services and mental health toolkits to employers. However, this is unlikely to fully compensate for cuts. There is a need for long-term, stable funding for preventative work.

ACHIEVING PREVENTION THROUGH STRONGER INTEGRATION

Our research found that Health and Wellbeing Boards (HWBs) could be much more focused on addressing the wider determinants of health. According to our survey, only 38.8 per cent of DsPH agreed their HWB was effective in addressing the wider determinants of health. When probed on why this was the case, interviewees felt that HWB discussions are weighted towards health and care integration and short-term demand management in healthcare.[4] While this can have positive outcomes for individuals and services, this focus reduces the time and resources to address the wider determinants of health.

"If the HWB wanted to improve economic health, how many conversations have we had with them about increasing job opportunities, post-16 learning etc.? None. All energy still goes into primary care discussions"
Local Government Officer

Stronger HWBs would also be able to influence other local policy structures, such as Sustainability and Transformation Plans and combined authorities. Currently, interviewees felt that opportunities to influence these structures had been limited.

4 Also noted as a challenge in Hunter, D. et al (2015). Evaluating the leadership role of Health and Wellbeing Boards as drivers of health improvement and integrated care across England: Interim Report No 2. Durham University.

SUMMARY OF REPORT RECOMMENDATIONS

The report recommends some key areas for public health teams to focus on:

■ Public health teams and economic development teams should work much more closely together. This must be based on clear recognition that good health and employment are closely linked, as are poor health and worklessness.

■ Collaboration on public health between county and district councils should be developed. In two-tier areas, district councils are key partners for public health with levers such as housing and planning.

■ In order to better target action, public health teams should develop stronger relationships with services responsible for groups facing poor health outcomes, in particular agencies in the criminal justice system.

To enable public health to extend its influence, the report recommends that:

■ Health and Wellbeing Boards (HWBs) are given the power and resource to drive forward long-term prevention initiatives. To ensure HWBs are able to address the wider determinants of health, the report makes a series of recommendations on how this could work in practice.

■ Public health workforce development incorporates the need for 'soft skills' as well as technical skills. We recommend that national bodies such as the Local Government Association facilitate peer-led training and development initiatives for public health teams on influencing and communications skills.

■ To extend the influence of public health, councils should embed a culture of health in all practice and policy. Reflecting the need for public health to see its role as networking and enabling, teams should develop 'health champions' across local services who are already advocates for improving health and can promote public health initiatives among their peers.

- Central government must support long-term funding for preventative initiatives. Local government finance faces continuing pressure, with reduced grant and lack of clarity over the future of business rates retention. Cuts have been made to the Public Health Grant. We recommend that central government clarify the funding situation for local government in general, and public health in particular.

INTRODUCTION

Prevention is fundamental to public health. The 2013 transfer of public health teams to local government was an opportunity to influence the range of local services which affect the wider determinants of health: services like housing, planning and transport. The transfer[5] promised a shift towards stronger prevention and the closer coordination of existing resources to promote healthy outcomes. While the move has been in many ways successful, it has not been without its challenges.

Strengthening our approach to prevention has never been so urgent. Demand on public services has reached an unsustainable level as funding cuts have happened at the same time as rising need – with an ageing population, sharp health inequalities and increasing levels of multi-morbidity.[6] The only way to sustain public services and improve outcomes is to get better at prevention.

But funding has faced increasing pressure. In-year, and then year-on-year, cuts are eventually morphing into the complete removal of the funding ring-fence by 2019. At the same time, there is an ongoing reduction in central government funding combined with confusion about the move to full business rates localisation. There have been reports of variations in performance between local authorities with concern that there are not robust systems in place to address these issues. A Health Select Committee report indicated tensions between political and evidence-based priorities.[7]

While other research has explored the transition,[8] this report focuses specifically on the different ways in which public health could influence, and

5 In 2013, most public health functions moved from the NHS back to local government. Local authorities now have a statutory duty to improve the health of their populations and councils assumed responsibility for some core public health services including the 'mandated services'. These are: sexual health services, the NHS Health Check programme, health protection, public health advice, the National Child Measurement programme, and public health services for 0–5 year olds.

6 The King's Fund (2012/13). Long-term conditions and multi-morbidity

7 House of Commons Select Committee (2013). Public Health post 2013.

8 For example, Marks et al (2016). Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision. Results of a national survey. Durham University, Coventry University, University of York, Voluntary Organisations' Network North East.

is influencing, the wider determinants of health, what the challenges are, and where there is potential to go further.

Overall we found that public health teams have transitioned well, but there is still more to do. Public health teams have an opportunity to extend their reach to influence the full range of place-based services which improve health at a whole population level, preventing poor health before it ever occurs. Public health in local government has the chance to shape some of the broadest factors that affect the health of all of us over the life course such as where we live and where we work. Our research found that there is potential to do much more work in some of these areas.

Public health teams in councils have the potential to extend their reach, move upstream and influence factors like the local economy, housing, and work. This is key to preventing health inequalities, so that the street where we were born does not influence how long we will live and how well we live.[9] Moving upstream and strengthening preventative work means people will lead happier, longer, healthier lives and could potentially generate savings for local services. Previous estimates have calculated that health inequalities cost £20-32 billion per year in lost taxes and welfare payments.[10]

The report initially 'sets the scene' by giving an overview of public health team's progress since 2013. There has been particular progress in building links with people-focused services such as adult social care and children services.

In Chapter 1, we outline some of the key partners with whom public health needs to develop stronger links. Local economic development departments hold influence over local growth and employment, while in two-tier areas district councils hold responsibilities in planning and housing. Effective prevention through links with councils' place-based services will mean lower incidences of disease and poor health conditions. There is also an opportunity to strengthen links with agencies in the criminal justice system, which will have a benefit on the health of offenders and the communities they come from.

[9] Dorling, D. (2013). Life on London's Central Line. London: Penguin. Data from the report available at http://www.dannydorling.org/books/centralline/Figures_and_Data.html
[10] Marmot, M. et al (2010). Fair society, healthy lives: Strategic review of health inequalities in England post-2010. The Marmot Review Team.

Yet there continue to be barriers to extending the influence of public health that need to be addressed locally and nationally. We explore these in Chapters 2-4.

Chapter 2 explores how to overcome the cultural barriers. The need for public health teams to adjust to working in a different environment has been widely noted in reviews of the transition to local government.[11] The Director of Public Health (DPH) is a statutory position but a DPH does not wield the same level of influence in all councils. Our research shows that most Directors of Public Health (DsPH) previously worked in the NHS, and did not necessarily have the experience of influencing in a local government context. While many now feel positive about working within local government and are adapting, our research identified that there is still a need for the soft skills to lead and persuade local place leaders.

Chapter 3 shows how the financial barriers faced by local government and public health teams specifically are reducing, and how councils are adapting. Initially the transfer was accompanied by a ring-fenced grant. But public health funding in local government has faced increasing pressure. Locally, public health teams are maximising their resources to best effect but are limited in a wider system focused on short-term demand reduction rather than long-term prevention.

As we explore in the final chapter, local structures such as Health and Wellbeing Boards need to be more substantially empowered to address the wider determinants of health. Many interviewees felt that local structures that help to achieve prevention are still weighted towards health and care integration and short-term demand management in healthcare.[12] This does not leave the capacity to address the wider determinants of health for the whole population.

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11 House of Commons Select Committee (2013). Public Health post 2013
12 Also noted as a challenge in Hunter, D. et al (2015). Evaluating the leadership role of health and wellbeing boards as drivers of health improvement and integrated care across England: Interim report No 2. Durham University.

HOW WE COMPLETED THIS REPORT

The research used a mixed methodology combining quantitative and qualitative methods. A detailed methodology is available in Appendix 1.

Our methods included desk-based research, a workshop, in-depth interviews and a roundtable with stakeholders, and surveys. We designed and distributed three separate surveys[13] and received over 400 survey responses from the three surveys. (Further details about the surveys can be found in Appendix 2.) We carried out case studies between August and September 2017 with over 40 stakeholders in Devon County Council, Camden and Islington Councils, and Darlington Council. Experts in public health and local government gave comments and feedback on early drafts.

We focus on the opportunities for change at a local level: on the role of public health in local government and the effect on the wider determinants of health. We acknowledge that some public health functions still sit within NHS England and some of the most significant policy influences on health sit nationally, but these are not in the scope of this report.

13 The three groups were senior public health officers and DsPH (abbreviated throughout for brevity as DsPH respondents), non-public health officers from across the council, and elected members.

SETTING THE SCENE: AN OVERVIEW OF THE PROGRESS IN PUBLIC HEALTH SINCE 2013

When public health teams moved into local government it presented an opportunity to strengthen links with place-based services and have greater influence over the wider determinants of health. To succeed in this, public health teams needed to build impactful relationships with council departments and local place-based services in other sectors which affect the determinants. Our research sought to investigate this.

This section presents our findings from our survey and interviews with local government officers, councillors and public health teams,[14] reviewing the extent to which public health teams have influenced local services within and outside local government. It finds that public health teams have made substantial progress in some areas, but there are some significant gaps.

RELATIONSHIPS WITHIN LOCAL GOVERNMENT

"We are looking at a lot of additional areas we never would have had the chance to in a PCT [Primary Care Trust] setting, and working jointly with people in other directorates." **Senior Public Health Officer**

Four years on from the transfer, public health has made very positive inroads. Nearly 88 per cent of non-public health officers that we surveyed agreed that public health had engaged with other departments in their council and 88.7 per cent of elected members agreed that public health had engaged with members in their council. Over 55 per cent of Directors of Public Health (DsPH) respondents had added new services to address the wider determinants of health as a result of the move.

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14 More details about our research participants are available in Appendix 2.

Looking at this in more detail, people-focused departments such as children's services, adult social care, culture and leisure, and housing were the most engaged with public health, according to DsPH respondents (Figure 1). This was a finding that was also echoed by non-public health officers. Other research[15] also suggests that public health has integrated particularly well with social care. On the other hand, economic development departments were among the least engaged with the public health remit. Our survey shows that only 12.8 per cent of DsPH respondents felt that economic development departments were very engaged; by contrast, 64 per cent of DsPH respondents felt that children's services departments were very engaged.

Looking specifically at two-tier collaboration, we found that district councils were engaged but there were opportunities to bring them in further to important parts of public health. District council officers responding to our survey were less likely to feel engaged by public health and less likely to feel they had been involved in the creation of the Joint Strategic Needs Assessment (JSNA).[16]

Our research revealed many examples of joint actions which have emerged as a result of engagement with other council departments, in areas such as cycling initiatives, weight reduction, tobacco control, healthy eating and education, domestic abuse, open space and parks, and homelessness reduction. In one area, public health staff were placed within a housing team to deliver a programme of health and wellbeing activities on housing estates, such as free exercise and cooking classes for residents. Other examples included a joint project to develop a road safety strategy based on the Vision Zero[17] principle that no loss of life is acceptable. This was done instead of the standard update proposed, demonstrating the value of public health in enabling other departments to seek innovative new approaches to health and safety.

In some cases, services have been recommissioned to be more joined-up across the locality. One public health team we spoke to had integrated their health visitor services with the wider early intervention offer, placing health visitors working with parents and young children in children's centres. This

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15 Local Government Association (2017). Public health transformation four years on: Maximising the use of limited resources.

16 31.8 per cent of district council officers said the public health had engaged them through the JSNA compared to 54.97% of all non-public health council officers.

17 See http://www.visionzeroinitiative.com/

helped to provide more effective support to children who may be at higher risk of poor health outcomes throughout their lives, helping to achieve Marmot's policy objective to reduce health inequalities by giving every child the best start in life.[18] Health visitors can also reach some families that social work teams may not be able to, as their service is not as stigmatised as social services.

FIGURE 1 LEVEL OF ENGAGEMENT WITH PUBLIC HEALTH REMIT, BY DEPARTMENT
(Public health respondents, n=87)
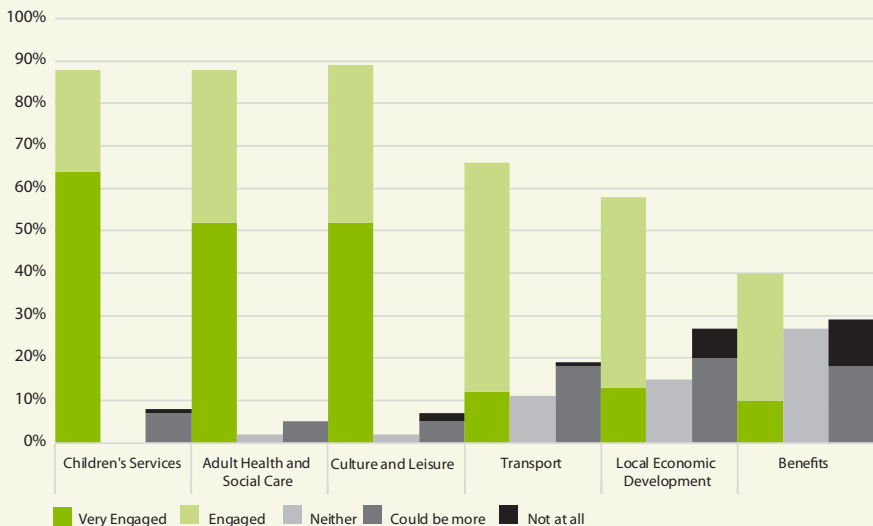
EXTERNAL RELATIONSHIPS

Externally, the highest levels of engagement were seen to be with clinical commissioning groups (CCGs). Additionally, public health teams seem to have particularly strong relationships with the voluntary sector — relationships that may be key to addressing the wider determinants of health.[19] Over 92 per cent of public health respondents said they are collaborating with the voluntary and community sectors (Figure 2). The strong relationship between public

18 Marmot et al (2010). Fair society, healthy lives.
19 Lamb et al (2017). Keeping us well: How non-health charities address the social determinants of health. NPC.

health teams and the voluntary sector has helped to develop social capital in communities and improve mental health. For example, in one area the public health team have linked people with substance misuse issues with the local community allotments. A positive social network and meaningful role are both key to recovery from drug and alcohol use, and relationships with community organisations have helped to provide these. One voluntary sector interviewee felt that the position of public health in local government helped to recognise the importance of social, non-clinical factors such as this for health:

"For years, drug and alcohol was seen through a criminal model or a medical model – public health has changed that by highlighting a lot of social issues which are the core reason why people are in the position of using drugs and alcohol." **Voluntary Sector Worker**

FIGURE 2 EXTERNAL AGENCIES COLLABORATING WITH PUBLIC HEALTH
(Public health respondents, N=81)
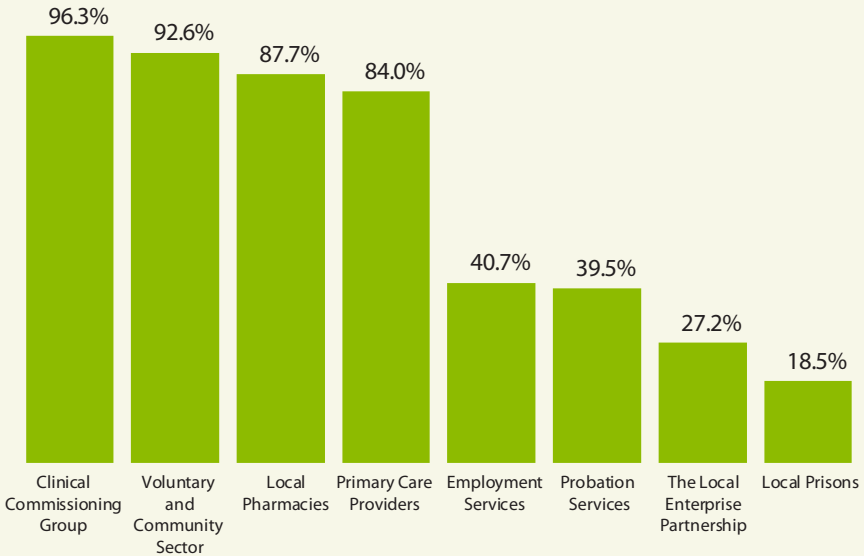
From our qualitative research, engagement with Sustainability and Transformation Plans (STPs) has been patchy. STPs have been set out for 44 geographical footprints covering all aspects of NHS spending in England

over the next five years. Some lack sufficient public health expertise,[20] but our survey also identified some positive progress which others could learn from. One survey respondent noted that their public health team worked with health and social care partners in the development of a Prevention at Scale programme in their local STP – a pan-county initiative to scale public health interventions across the NHS and social care system, working across two Health and Wellbeing Boards and led by public health.

There are some local public services which were considered less engaged, and our survey showed low levels of engagement with probation services and prisons.

CUTS AND CHANGES IN COMMISSIONING

There have been some challenges. Local authorities have made significant cuts to public health services following reduced budgets. In 2016, analysis found that local authority spending on public health between 2015/16 and 2016/17 had reduced by nine per cent with the biggest cuts being to smoking cessation services and public health advice to NHS commissioners.[21] Our own survey found that over 70 per cent of DsPH respondents stated cuts had been made within their public health team. Many respondents pointed to the decommissioning of services in areas like smoking cessation, weight management, and drug and alcohol services. However, this does not necessarily mean that these services are no longer being provided. In some cases, respondents acknowledged that decommissioning had resulted in the recommissioning of services at lower contract value, and the redesign of services to reduce duplication. Further evidencing this, a 2015 report found that 54 per cent of 189 substance misuse support providers studied had been through a re-tendering process since September 2013.[22]

THE WAY FORWARD

Despite financial challenges, public health teams in councils appear to have forged positive new relationships as a result of sitting within local

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20 Provider Voices (2017). Public Health: Everyone's business? NHS Providers.
21 Buck, D. (19.8.2016). "Local government public health budgets: a time for turning?". The King's Fund.
22 Drugscope (2015). State of the sector 2014-15: summary report.

government. Local government has the potential to provide a platform for public health to address issues further upstream. While overall, the story is positive and both public health teams and local government departments have worked well together since 2013, we found that there is more to do both internally within the council and with community stakeholders. The next chapter looks to the future and shows that going forward, widening the influence of public health could boost its ability to move upstream, and thus improve whole population health and reduce health inequalities. The chapters following this will look at how public health teams can do this.

1. NEW RELATIONSHIPS FOR PUBLIC HEALTH

Since public health teams moved to local government, they have developed strong relationships with people-focused services such as social care and the voluntary sector, resulting in a strengthened public health offer locally. But to move futher upstream, the influence of public health must go even further. It will need to extend to place-shaping services like economic development and housing and planning within district councils in two-tier areas. Relationships with these services provide an opportunity to tackle the causes of poor health before they begin. A stable, good quality job and decent home strongly determine someone's health over a lifetime, and their children's health from before they are born.[23]

Our survey and case study findings identified three potential new relationships to explore in further detail. The first relationship is with local economic development, given the strong relationship between growth, employment and health outcomes.[24] The second relationship is with district councils, which hold responsibility for some of the most significant wider determinants of health including planning and green space.[25] The third relationship is with organisations such as probation which work with groups who experience some of the poorest health outcomes.

RECOGNISING THE ROLE OF THE LOCAL ECONOMY

"I joke that even if all the [public health] grant went into getting people a job that wouldn't be the worst thing, as it's such a key determinant!"
Director of Public Health

As noted in Figure 1, according to DsPH survey respondents, those responsible for economic development within councils were among the least engaged with the public health remit of all council departments. Externally,

23 Marmot et al (2010). Fair society, healthy lives.

24 Marmot et al (2010). Fair society, healthy lives.

25 Buck, D. and Dunn, P. (2015). The district council contribution to public health: a time of challenge and opportunity. The King's Fund.

public health teams were also less likely to engage with employers. Figure 4 shows that only 4.9 per cent of Health and Wellbeing Boards have representation from employers.[26]

Yet the local economy, and access to good quality work, is a major determinant of health. Long-term unemployment worsens health in three important ways: financial problems which affect living standards; depression or anxiety triggered by a lack of a positive self-identity; and its association with poor health behaviours such as alcohol consumption.[27] It is important that public health teams develop stronger relationships with stakeholders who devise strategies to boost growth and employment at a place and individual level.

As well as unemployment, low paid, poor quality work can also be harmful to health. A recent study tracking unemployed adults moving into work found that those who transitioned into low pay or stressful jobs experienced poorer mental health following the change.[28]

We found that councils have made progress in recognising the relationship between health, work and the economy. They have developed initiatives to support people to go back to work and made links with employers to address poor physical and mental health in the workplace, as explored in Case Study 1. In Redcar and Cleveland, the public health team have worked closely with local health services and advice services within the council to help to support people to deal with the impact of the steelworks closure and the loss of 3,500 jobs.[29]

In general, however, there is still potential to go further and ensure health is explicitly addressed in growth strategies and in local structures and partnerships which address economic development. If local growth is not inclusive and does not provide jobs for the poorest, it is likely to worsen health inequalities. If public health had greater influence over growth strategies, public health teams could help to ensure that the strategies are inclusive and reflect the need for *quality* work. There is a clear need for public health teams to work more closely with those responsible for these growth strategies.

26 Excepting those employers represented in another capacity.

27 Marmot et al (2010). Fair society, healthy lives, p.69.

28 Chandola, T. and N. Zhang (2017). Re-employment, job quality, health and allostatic load biomarkers: prospective evidence from the UK Household Longitudinal Study. International Journal of Epidemiology, August 2017.

29 LGA (2017). Public health transformation four years on: Maximising the use of limited resources.

CASE STUDY 1: CAMDEN AND ISLINGTON'S WORK WITH KEY PARTNERS

Camden and Islington are inner North London boroughs, with a combined total population of around 462,000. The councils share a public health team which provides an opportunity to exchange insights and resources for shared challenges across the two boroughs such as employment and wellbeing. High levels of health-related worklessness exist within both Camden and Islington, and this is particularly prominent amongst residents with long-term illnesses or disabilities.

Recognising the importance of employment and, in particular, good employment to improved wellbeing, Islington have brought together senior representatives from the council, local NHS, and relevant external partners including Jobcentre Plus to establish a Wellbeing and Work partnership to improve health outcomes for local residents with a long-term health condition or disability and those at risk of long-term sickness absence. It does this through developing, testing and learning from new types of employment support; workforce development and awareness raising amongst health care professionals and employment coaches of the links between work and wellbeing; improving referral processes and quality of employment support services; and engaging local employers to support and recruit staff with physical and mental disabilities alongside promoting workplace wellbeing. Thus far the partnership has supported the implementation of two pilots to support residents who are in employment and off sick to be supported back to work. The partnership worked with NHS England to fund a trial to support people who are unemployed or on long-term sick leave back to work.

Similarly, Camden Council together with Jobcentre Plus have commissioned three employment-support programme pilots targeted at those furthest away from the labour market and at those with multiple and complex barriers to employment. The aim was to test and build evidence of different approaches to support clients to access and sustain employment past six months, including Individual Placement Support (IPS) principles being tested in two of the

three pilots. The three pilots have focused on people with serious and common mental illness and those with learning and physical disabilities and other long-term health conditions.

Across both councils, the public health team has been working with local employers to offer both resources and capacity to promote workplace wellbeing, in recognition of the growing importance of the workplace as a setting for improving public health. The team work with local employers and engage with local business networks to promote activities such as mental health training. The Healthy Workplace Charter is a three-tier awards system incentivising employers to implement place-based measures at work. To date, 30 businesses from a range of sectors across Camden and Islington are taking part in the charter.

More information about Camden and Islington's approach is available in Appendix 3.

TWO-TIER COLLABORATION ON PUBLIC HEALTH

"Districts can provide local knowledge of small rural areas – the machine back at the ranch doesn't always get it." **District Council Officer**

In two-tier areas, counties hold public health responsibilities. This fits well with other county responsibilities such as libraries, education, and social care. District councils also play a key influencing role as they hold responsibilities for areas like economic development, planning and housing – key levers for addressing the wider determinants of health and moving public health upstream. While overall, engagement with housing departments was good (with 84.1 per cent of DsPH saying these departments are engaged in public health), our research raised the need to boost engagement in two-tier areas specifically.

District and county councils have a strong impact on each other's public health-related outcomes. As Figure 3 shows, while county councils are responsible for services such as adult social care, both counties and districts are responsible for housing and district councils are responsible for planning. While counties hold responsibility for ensuring good public health, practically, both county and district councils hold levers to affect public health. For instance, a failure to prevent homelessness or respond

to it effectively will drive up demand for expensive health and social care services. Pressure on social care budgets will impact on homelessness, and create a significant increase in demand for emergency housing, rough sleeper numbers, and anti-social behaviour incidents involving poor mental health — all of which are district responsibilities. Integrating health into area planning is an opportunity to promote good health outcomes at a whole population level. How much people walk and how many social connections they have is determined by the layout of their neighbourhoods, their access to green space and local transport infrastructure.[30]

FIGURE 3 PUBLIC HEALTH INTERNAL RELATIONSHIPS[31]

30 Harvey, A (2017). Building homes, growing communities. NLGN.
31 Mansfield, C. (2013). Healthy dialogues: embedding health into local government. NLGN.

However, district councils receive no direct public health resource and they are not statutory consultees on Health and Wellbeing Boards. Previous NLGN research identified that the role of district councils in influencing health is not always fully understood[32] and a more recent report identified that district councils need more resources for 'health economics' and capturing the value of what they do on health.[33]

District council officers responding to our non-public health officers' survey were less likely to feel like the public health team engaged with them. A considerably smaller proportion of district council officers felt engaged compared with unitary officers (78.4 per cent compared to 97.5 per cent of unitary officers). More worryingly, district council officers were comparatively unlikely to have been involved in the creation of the JSNA.[34] The JSNA is a key document to understand in depth the local population's health needs and strategic responses to this. It is important that district councils' unique insight into their population is captured.

County councils have found ways around the challenges of two-tier working, however, working with district councils to provide targeted, inclusive health advice. For example, Suffolk County Council worked closely with Babergh and Mid Suffolk District Council to provide health advice to people living in council homes. In Devon, despite having the sixth lowest Public Health Grant per capita of anywhere in the country, the county council originally earmarked £20,000 to each district for the first three years for locally-led initiatives.

Previous NLGN research has identified that district councils are not always sufficiently consulted on public health or represented on Health and Wellbeing Boards in some areas[35] and it was suggested that the statutory duty to improve public health should be cascaded to districts. However two-tier collaboration is achieved, it clearly needs to be strengthened so that both counties and districts benefit from shared insight and strategies on health.

32 Mansfield, C. (2013). Healthy dialogues: embedding health into local government. NLGN.
33 Buck and Dunn (2015). The district council contribution to public health: a time of challenge and opportunity.
34 31.8 per cent of district council officers said the public health team had engaged with them through creation of the JSNA compared to 54.97 per cent of all non-public health council officers.
35 Mansfield, C. (2013). Healthy dialogues: embedding health into local government. NLGN.

REACHING MARGINALISED GROUPS

Our findings also suggest there is an opportunity to develop stronger relationships with organisations working with marginalised groups who experience some of the worst health outcomes — in particular, local criminal justice agencies. Probation services were rarely represented on Health and Wellbeing Boards with only 9.9 per cent of survey respondents indicating representation, and neither were prisons with no respondents indicating representation, as shown in Figure 4. Yet improving health outcomes for people in contact with the criminal justice system has a wide benefit. Prisoners and people on probation experience high levels of mental illness, social exclusion and homelessness.[36] More widely than this, offenders tend to come from deprived, under-served communities, so working with them can improve the health and safety of their families, friends and children. Children of offenders are more likely to have mental health problems compared to their peers, while communities who fear crime are dissuaded from healthy behaviours.[37]

FIGURE 4 SERVICES WHICH HAVE REPRESENTATION ON THE HEALTH AND WELLBEING BOARD (Public health respondents, N=81)
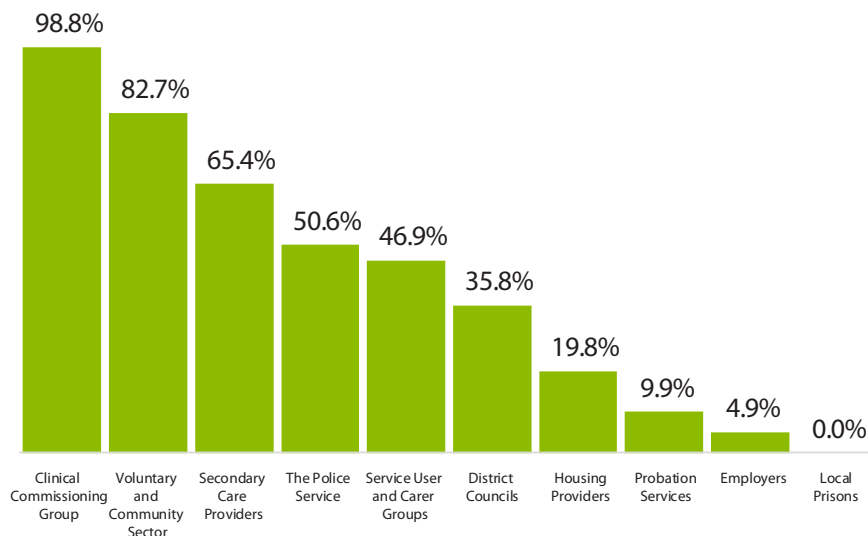
36 Revolving Doors (2013). Balancing act: addressing health inequalities among people in contact with the criminal justice system.
37 Anders, P., Jolley, R., Leaman, J (2017). Rebalancing act. Revolving Doors.

We discussed with interviewees why there are these low levels of engagement and some interviewees admitted that if they do not have prison on their patch, they do not immediately see this as a priority. While only 39 per cent of local authorities have prisons within their area,[38] many more will have prison leavers returning to a locality. Each year, 60,000 people serve prison sentences of less than 12 months and this group often experience poor mental and physical health as well as drug and alcohol problems.[39]

In some cases, public health teams have developed relationships to improve health outcomes for these groups. In the London Borough of Sutton, the public health team worked with community safety and the local probation service (Community Rehabilitation Company, CRC) to create a dedicated centre for women in contact with the criminal justice system. These women have a range of health needs, and the centre provides holistic support, working in partnership with different agencies. This helps to both reduce reoffending and improve health outcomes. For example, women have been supported to access their GP as part of the GP offender registration programme, piloted by Sutton and Hounslow councils. This scheme came about as a result of concern that people leaving prison were not accessing their GP and faced barriers if they had no fixed address or ID. Supervising probation officers were able to issue a letter of ID for a GP on behalf of the offender to register at a local surgery in conjunction with the ability to use the local probation or youth offending service office as a proxy address when the individual had no fixed abode. Developing joint initiatives with CRCs (which now deliver probation services for most short-sentence prisoners) is an effective way to address offender health and therefore the health of deprived communities more widely.

CONCLUSION

Four years on from the transfer of public health to local government, it is a good time to extend the reach of public health and develop some under-used opportunities to influence the wider determinants of health and move

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38 PHE (6 July 2015). The community dividend: why improving prisoner health is essential for public health

39 Howard League for Penal Reform (2011). No winners: The reality of short term prison sentences.

upstream. Health is determined by the environment, work, housing, and place, and so relationships with stakeholders who influence these factors should be strengthened. Improving the health of offenders should be a high priority for public health teams; this will benefit both this under-served group and deprived communities more widely. However, there are some barriers to extending the reach of public health. These include cultural challenges, reduced financial resources, and the capacity and focus of integration structures. In the next chapter, we will explore how skills development is key to overcoming some of the cultural challenges.

2. STRENGTHENING THE IMPACT OF PUBLIC HEALTH: SKILLS

We have addressed the areas where public health needs to develop stronger relationships. This chapter looks at how to make this happen. Key to this will be influencing skills, whether this be the skills to engage councillors, other local government departments, public sector colleagues or the public. Almost all of the DsPH (93.7 per cent) we surveyed agreed that since the transfer, their workforce needs different skills with 'communication and influencing' and 'storytelling with data' as the top skills identified as being needed more.

Traditionally, public health staff had strong clinical and/or analytical skills, particularly those who worked within the NHS (82.7 per cent of our DsPH respondents had previously worked within the NHS). A different environment demands different skillsets: in particular stronger 'soft skills' of persuasion, relationship building and communication, to adapt to the democratically accountable environment of local government. These influencing skills will be important to extend the reach of public health across a whole locality in the long-term. In the short-term, public health teams can build stronger relationships through using practical techniques to embed public health across a locality.

DEVELOPING THE SKILLS OF THE PUBLIC HEALTH WORKFORCE

Public health teams are highly skilled at influencing the health behaviours of the public. Working to change the behaviours of whole cohorts of people is core to public health. We heard many examples of how public health teams are using sophisticated techniques to influence the public. For example, the use of behaviour change techniques, which exploit subconscious influence on human behaviour, such as the messenger (we are heavily

influenced by who communicates information) and norms (we are strongly influenced by what others do).[40] In Darlington (Case Study 2), an interesting approach to 'nudging' people towards healthy behaviours has been found in collaboration with schools. A Healthy Lifestyles survey explored the prevalence of issues such as alcohol and drugs, consent, the media, and sex and relationships among children within school Years 5-11. By sharing key facts about the reality and prevalence of sexual practices as part of PSHE (Personal, Social and Health Education), the findings are used to encourage young people into safer practices.

CASE STUDY 2: DARLINGTON COUNCIL: DEVELOPING NETWORKS OF INFLUENCE FROM A SMALL TEAM

Darlington Council's public health function is small, yet highly influential. The small size of Darlington Council enables close-knit working across departments, and officers have access to senior members of staff without facing layers of bureaucracy. Developing strong relationships and effective techniques to engagement is fundamental to the influence of public health over wider stakeholders. This is particularly prevalent in their work with schools on sexual and mental health.

Ensuring the health and wellbeing of the school-age population is a public health priority in Darlington. The public health team commissions a Relationship and Education Sexual Health Coordinator to lead on sexual health initiatives and address problem areas such as poor sexual and mental health. This coordinator has proactively built a core network of influencers across schools and voluntary and community sector (VCS) services. Taking a relationship-based approach has been pivotal to get PSHE (Personal, Social and Health Education), which is non-mandatory, prioritised in Darlington's schools — all of which are academies.

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[40] Cabinet Office and Institute for Government (2010). Mindspace: influencing behaviour through public policy.

Darlington's public health team used the annual Healthy Lifestyles Survey as a needs assessment to create tailored, evidence-based reports for each school that decides to take part. This behaviour change approach uses data analysis to craft targeted interventions for prevalent issues.

Additionally, the results are used to bust myths about how prevalent certain behaviours, such as sexting, really are. The work has resulted in a girls' empowerment project, which will be delivered by schools' therapeutic workers. The public health team has bolstered the core offer for local schools and organisations by offering specialist skills and capacity in data, foresight and behaviour change. In doing so, they have ensured they are a valued resource, and can promote primary and secondary level prevention.

Recognising the importance of early intervention in addressing mental health needs, the public health team worked with Darlington Clinical Commissioning Group and Healthwatch to increase their offer to schools. As part of this, the public health team have delivered mindfulness and wellbeing training to teachers. This has formed part of the local action plan and national strategy[41] to protect and improve children and young people's mental health.

More detail about Darlington Council's approach is available in Appendix 3.

However, influencing within the local government environment is an entirely different skill to shaping the behaviours of the public. Public health teams need to be able to persuade and influence senior stakeholders on a one-to-one basis. They need to be able to overcome power dynamics to successfully advocate for local public health priorities. Our survey responses suggested that the public health workforce was highly conscious of this area of skills development. 77 per cent of DsPH respondents agreed they had an increased need for communication or influencing skills and for the skill of 'storytelling with data'.

41 Department of Health (2015). Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing.

FIGURE 5 TOP SKILLS IDENTIFIED AS BEING NEEDED MORE

(Public health respondents n=74)

Both skills are crucial for influencing different stakeholders in a locality. Where communication styles differ, this can be a stumbling block from the beginning:

"The language isn't translated well in the local authority. Even the word public health. If it was called healthy environments or healthy communities, it would be easier to understand." **Local Government Officer**

Storytelling with data is about being able to craft the narrative that emerges out of the evidence in a compelling, persuasive and authoritative way. Being able to translate complex data into clear, evidence-based recommendations is crucial to influencing local structures and stakeholders.

Without these skills, public health teams will not be able to shape local strategies. As local government gets ever more complicated and more challenging, it is crucial that public health can establish itself as a credible voice. This is essential to keep a focus on prevention whilst other voices advocate for crisis-focused services. However, some interviewees felt that this was not something that directors of public health are prepared for:

"Most directors of public health have never been taught to lead systems across scale, they've been taught to be technicians."
Director of Public Health

To influence the full range of the wider determinants of health, public health needs to be a powerful strategic voice across a locality. Part of this is being able to skilfully engage elected members.

SKILLS AND THE POLITICAL ENVIRONMENT

"The very good public health teams have tools or mechanisms to engage with councillors and are successful. The less successful ones have stayed within a technical sphere." **Director of Public Health**

The democratic nature of local government provides unique benefits to public health. Part of the argument for public health moving into local government was to increase the degree of local democratic oversight. Members can be a source of intelligence on hyperlocal health trends, picking up on patterns before they appear in official statistics – especially for 'hidden' and transient communities, such as migrant workers. Members can promote a healthy lifestyle: in Darlington, elected members held 'walking surgeries' where they encouraged the public to join them in walking their dogs and simultaneously help to resolve constituency issues (Case Study 2 in Appendix 3). The general sense among the public health professionals we spoke to was that this is a strength.

"I like it when members tell me they are representatives of the people, and that something matters more or less in that regard. It feels fairer than the levels of bureaucracy that determined what we did in the PCT days."
Director of Public Health

Nevertheless, the dynamic between politician and public health teams is still being developed. Some have expressed concern about local politics rather than evidence determining spending priorities, which could be detrimental to services for more stigmatised groups.[42] This was also a concern to the public health teams that we surveyed with 80.8 per cent of respondents agreeing that local politics can come into conflict with evidence-based approaches

[42] Davies, A. et al (2016). Public health and prevention. Quality Watch.

to public health (although the effect on more stigmatised services was not highlighted as an issue in any specific area). Roundtable attendees discussed that politicians need to be able to show their constituents tangible evidence of local investment, so, for example, they may advocate for outdoor gyms. On the other hand, public health teams may not feel that these are the most strongly evidenced health interventions.

Both public health teams and non-public health officers we interviewed felt that, in order to be able to advocate for the most important health priorities, public health teams needed to be able to communicate and influence more effectively. Of DsPH respondents, 46.8 per cent disagreed and 19 per cent were unsure that current education and training pathways equip public health workers with the necessary skills. Until 2015, official training for the public health workforce did not reflect new skills needed by public health professionals. Besides, so-called 'soft skills' may be better addressed through practical application. It tends to be a mixture of experience and peer support that help officers in other departments adapt to a political setting and this is something that could be encouraged within public health teams. Some public health officers have developed particularly strong communication and influencing strategies when working with elected members, with scope to formalise this into a peer-to-peer training programme.

GREATER IMPACT THROUGH EFFECTIVE RELATIONSHIPS

In the long-term, these new skills requirements will need to be addressed through training, but in the short-term there are practical approaches to developing stronger relationships between the public health team and the councillors, officers and local public services who play a role in addressing the wider determinants of health. There were two particularly innovative approaches to embedding public health across a locality – a cultural technique of expanding public health through a 'snowball' approach, and a structural technique of integrating public health within the organisational structure.

THE SNOWBALL APPROACH

"Everything we do beyond [statutory] is about persuading others to do out of goodwill." **Council Chief Executiv**e

Some public health teams have used the 'snowball' technique to enhance their influence. In this technique, the public health team trains and develops enthusiastic staff in other public services and other council departments to work with their peers on public health initiatives. Initially, this involves working with non-public health professionals who are already supportive of a public health goal, who will then go on to train their own colleagues to also contribute to improving health.

For example, in one area the public health team wanted to improve children's mental health by training teachers in mindfulness. Teachers have little spare time and may not see mental health as a part of their job. To overcome this barrier, the public health team began their work with a small group of teachers who were already passionate about improving children's mental health. This group then trained other teachers, and the programme was embedded across local schools. Using this 'snowball' technique, public health teams can develop networks of 'influencers' who promote messages around healthy lifestyles, ensure policy and practice contributes to health outcomes, and feedback intelligence about local need.

ORGANISATIONAL STRUCTURE

"The public health team was in danger of working just around the people side [of local government], but it's also working with environment, economy, workforce, businesses – that's where we try to embed it."
Local Government Senior Officer

The above 'snowball' technique is about leveraging goodwill and personal support. There are more formal ways to strengthen the impact of public health. Where the public health team sits, both physically and organisationally, can have an impact on its ability to influence. Currently, the most common placement of public health teams is under another directorate (Figure 6) and this is usually the people-focused directorate for social care and safeguarding (based on qualitative research).[43] While, as identified earlier, this has had a positive effect on the influence of public health on people-focused services, it could also have had a negative effect on the influence of public health on

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[43] See also Marks et al (2015). Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision. Views of national stakeholders. Durham University, Coventry University, University of York, Voluntary Organisations' Network North East.

wider place-based services. It is therefore worth considering whether placing public health within social care directorates is always the best way to address the wider determinants of health.

FIGURE 6 WHERE PUBLIC HEALTH SITS WITHIN A COUNCIL

(Public health respondents, n=98)
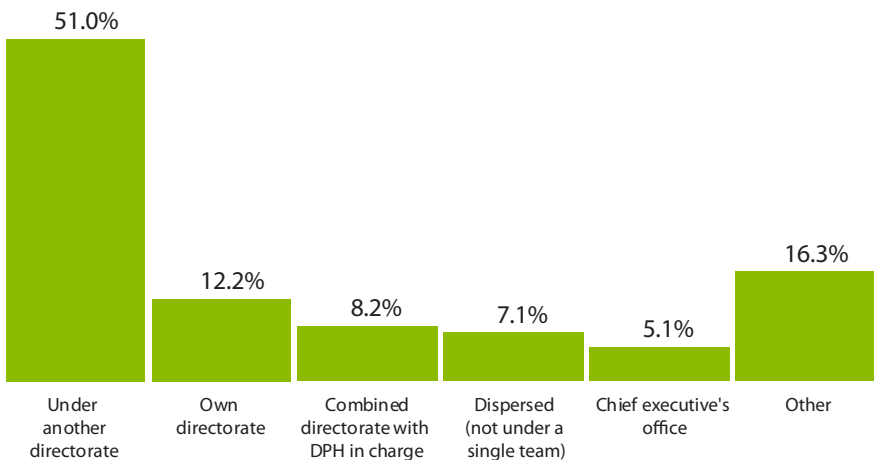
To ensure greater integration with all council services a small number of councils have placed public health within a combined directorate with the DPH leading and overseeing place-based services such as transport, leisure, and housing. As shown in our case study in Devon Council Council (see Appendix 3), this approach is effective when it has been tried, and has the benefit of ensuring that health is integrated into prevention-focused services such as planning and green space.

CONCLUSION

As public health teams become more ambitious about the scope of their influence at the local level they will need the influencing skills to embed a culture of health in all policy and practice. In the short-term, collaborative approaches and techniques will help to embed this culture. Leadership, influencing and communication skills are fundamental to influencing effectively. Councils and public health sector bodies should work closely together to consider the best ways to train the workforce in these skills.

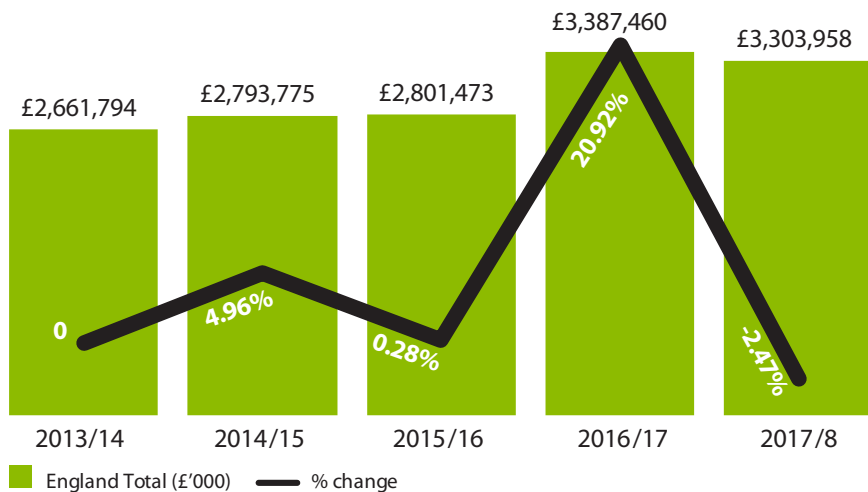# 3. STRENGTHENING THE IMPACT OF PUBLIC HEALTH: RESOURCES

The extent to which public health teams can influence the wider determinants of health is also impacted by reduced budgets and fewer resources. Recently there have been cuts to local public health budgets and, as of 2019, the ring-fence on funding will be removed. As budgets have changed, this has led to questions of what exactly the Public Health Grant should be used for and how to be financially sustainable. To adapt, public health teams are finding new ways to fund public health as well as using resources in a more targeted way. Based on our survey of Directors of Public Health (DsPH), 55 per cent of respondents were considering ways to generate more revenue in order to adapt to the new financial landscape.

USING THE PUBLIC HEALTH GRANT TO ADDRESS THE WIDER DETERMINANTS

Initially, councils received a public health funding allocation that was higher than many in local government had expected with above-inflation increases for two years.[44] However, increased responsibilities and reduced resources followed. The Healthy Child Programme was transferred to local government in 2015, and more recently further cuts have been made to the grant (Figure 7).

The impact of the Public Health Grant within overall council budgets has shifted in the years since the transfer of public health teams to local government. While the Public Health Grant was initially dwarfed by the Revenue Support Grant, it is now around the same amount per head. Both the Revenue Support Grant and the Public Health Grant have been cut. This has led, unsurprisingly, to questions of whether scarce public health funds are being used appropriately by councils.

[44] Department of Health (2013). Untitled letter announcing the publication of 2013-14 and 2014-15 ring-fenced grants to local authorities.

FIGURE 7 PUBLIC HEALTH GRANT ALLOCATION: ENGLAND

£2,661,794 £2,793,775 £2,801,473 £3,387,460 £3,303,958

0 4.96% 0.28% 20.92% -2.47%

2013/14 2014/15 2015/16 2016/17 2017/8

■ England Total (£'000) ━━ % change

Sources: Department of Health 2016, Local Authority Circular, Public Health Ring-fenced Grant 2016/17 and 2017/18; Department of Health 2014, Local Authority Circular, Public Health Ring-fenced Grant Conditions 2015/16

FIGURE 8 PUBLIC HEALTH GRANT & REVENUE SUPPORT GRANT PER HEAD: ENGLAND

281.73 233.35 174.32 130.64 69.80

49 51 63 62 60

2013/14 **2014/15** **2015/16** **2016/17** **2017/18**

━○━ Revenue Support Grant/head (£) ━●━ Public Health Grant/head (£)
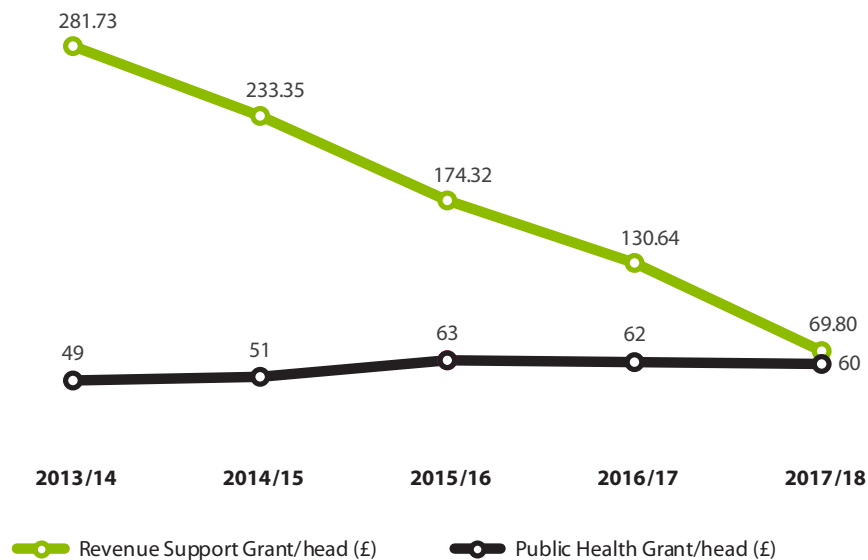
COMMISSIONING NEW SERVICES

Given funding cuts to local government, there had been a fear that the grant would be used for council services with a tangential connection to health – for example, fixing potholes or putting in flowerbeds. In 2015, research by the BMA suggested that many councils were 'plundering' their grant money to cover cuts to other areas of council activity. As the word 'plundering' suggests, the reporting of these findings framed this as an inappropriate use of public health funds.[45]

However, our research did not reveal any examples of the grant being used inappropriately. Rather, directors of public health were keen to acknowledge and recognise that non-clinical factors play a major role in affecting health. Of course, this does depend on how public health is defined:

"Old fashioned public health says fat people and smokers are the most important – but now I'm able with the money I have to actually say, no – homeless children are the most important, and if I save their lives with my budget, that's good..." **Director of Public Health**

Also challenging the notion that Public Health Grants were being used to maximum effect, 62 per cent of respondents reported that new services were being commissioned to address the wider determinants of health after 2013, in areas such as child health, trading standards, sports and leisure, libraries, drugs and alcohol, tobacco, housing, planning and environment, wellbeing in schools, food poverty, and young people not in education, employment, or training (NEET).

REMOVING THE RING-FENCE

The future of public health services depends on stable funding. But our research revealed considerable uncertainty about the removal of the ring-fence on the Public Health Grant. When directors of public health were asked to what extent the removal of the ring-fence was an opportunity, only 19.2 per cent agreed it was. In 2016, only 21 per cent of DsPH thought the ring-fence should be removed after 2018.[46]

45 British Medical Association (2015) Local authorities plunder ring-fenced public health funds.
46 Association of Directors of Public Health (2016). Impact of funding reductions on Public Health: ADPH survey results.

A few interviewees felt that, in theory, the ring-fence should be removed as public health work should be integrated across local government, not delivered and funded in silos. In practice, though there has been concern that removing the ring-fence will be the first step to cutting essential funds for prevention:

"I worry removing the ring-fence is an excuse to cut funding to the local authority. It's been done on council tax support and the welfare support scheme... So, I reluctantly support retaining the ring-fence."
Council Chief Executive

Given the uncertainty and concern about cuts to public health, there is a clear need for central government to provide assurance about future funding if it is to take seriously the need to 'radically upgrade' efforts to support prevention.[47] Public health interventions are cost-effective and can offer return on investment over the long-term, but it is essential that public health teams are given stable and sufficient resources.

MAKING THE MONEY GO FURTHER

In the absence of financial assurance however, public health teams are finding ways to sustain funding where they can. This section explores examples of how councils are doing this.

ALTERNATIVE FUNDING SOURCES

"We are thinking about what we can sell to the private sector – they're usually willing to pay for stuff. We're thinking about how could we take money from them, and pour into the VCS, like Robin Hood."
Local Government Officer

To adapt to reduced resources some public health teams are finding alternative sources of income. We found that public health teams were exploring different ways to finance prevention initiatives, such as commercialisation, joint working, and social finance.

47 Nuffield Trust, The Health Foundation and the King's Fund (2017). The Autumn Budget 2017: Joint Statement on health and social care.

COMMERCIALISATION: When asked whether they were finding ways to commercialise or generate revenues through public health, 54.7 per cent of DsPH respondents said they were. When probed on how they were doing this, respondents reported that they were selling services externally, for example through programmes or training, public health informatics services, various services to schools, and health products such as mental health toolkits to employers. Sometimes the commercial imperative appears to conflict with perceived public service ethos. We heard from one district council, which was struggling to maintain its environmental health protection standards as its budget continued to shrink, that member resistance prevented officers from developing a local authority traded service in environmental health advice. Instead, the district council had opted for a more conventional commercial landlord model.

JOINT WORKING: Several of those we interviewed had found ways to address the cross-cutting objectives of finding a more sustainable model for libraries, and delivering public health in a more cost-effective way. For instance, Sutton offer HIV tests and free condoms at their local libraries. Devon have also retained all 50 of their libraries despite a 50 per cent cut, by spinning the service out into Libraries Unlimited. By close relationships between Libraries Unlimited, the council, and the Clinical Commissioning Group – enabled through public health connections – Libraries Unlimited have pioneered an innovative Reading Well scheme, through which local GPs can prescribe condition-specific literature to residents. This has proven particularly useful in the area of mental health.

SOCIAL FINANCE: This was also considered by some authorities as an alternative route to funding future prevention. However, there are challenges, including the fact that the monitoring cycle for social impact bonds does not match up with commissioning cycles.

TARGETED RESOURCES

Public health teams are developing their own services to be more targeted and responsive to community insights, and are also helping the wider council more broadly to target its limited resources to best effect.

Some areas are adapting their approach to reflect the way that different groups exist across an area:

"People can be branched into three categories. One, 'inform me'. 'I use the internet, I have no time for meetings' — these people prefer to be supported digitally, and navigated to solutions. Two is 'enable me' - same but need a bit more, maybe a telephone call etc. Less dynamic but still self-directed. Then there is three - 'support me'. We were trying to support everyone which made no sense." **Assistant Director of Public Health**

Often, councillors' insights can be used to help public health teams target those 'support me' communities. In a time of limited resources, some of the interventions to support these groups will be co-produced, drawing on community assets.

To draw better on community insight, Cheshire West and Chester Council established a 'Poverty Truth Commission', with the strategic support of the public health team and the Health and Wellbeing Board. This created a space for people directly affected by poverty to tell their stories and influence those who make decisions, while challenging stereotypes and driving better decision making by leaders in the private, public and voluntary sectors. Intelligence from the Commission has informed public health's current and future decisions. The Commission was established in February 2017 after a launch where the lived experiences of 15 Community Inspirers were presented to an audience of 200 attendees from a range of organisations. As a result, three priorities were identified that the Commission would work on for the next 12 months to effect real change, including the relationship between mental health and wellbeing (the impact poverty has on people's mental health and vice versa); developing a person-centred approach (focusing on how people's experiences make them feel and what effect that has on their dignity); and benefit systems (supporting people to navigate current systems).

Public health teams can help other parts of the council develop a service delivery strategy that is informed by insights about different communities. One interviewee suggested that public health was 'more intelligent' as a tool for co-production than conventional commissioning departments and that, if properly resourced, it could accelerate co-production across various services in the future. For example, Devon County Council have used ethnography to

understand the lived experiences of people experiencing domestic violence, reporting that this allowed them to develop new insights which 'shifted their perspective from one of service systems to a citizens' perspective'.[48]

The ability of public health to draw together different organisational data sets, councillors' insights, and lived experiences, was demonstrated well by Devon's carpooling scheme for young mothers who had not been accessing the county's significant green space assets (see Case Study 3).

CASE STUDY 3: DEVON COUNTY COUNCIL'S TARGETED APPROACH TO COMMUNITIES

Devon is rich in environmental assets, rural areas and landscapes such as Dartmoor National Park. Green space offers a wide range of health benefits, particularly for mental health and physical fitness. As part of their green strategy, Devon County Council has created a Naturally Healthy working group, bringing together environmental providers, park managers, public health and health service staff to enable cross-sector working, oversee research and champion the naturally healthy theme. The strength of this umbrella partnership model lies in making key connections, promoting trailblazing ideas and updating existing providers and services so as to prevent replication.

In compiling a report for the Local Nature Partnership (Natural Devon) about improving engagement of the public with nature, Public Health Devon identified a number of key geographical areas where communities were not accessing the county's strong natural assets. This data was complemented by insight from a local councillor, that some of the deprived communities immediately adjacent to the National Park were not using the space, which was usually frequented by middle income families with cars.

The public health team spent time listening to these communities to identify the barriers to them using Dartmoor National Park. They found that transport was a key issue, and based on this feedback, supported the local community to develop their own car-sharing scheme to promote access to the moor.

More details about Devon's approach is available in Appendix 3.

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48 Quote obtained from one of our interviews.

CONCLUSION

Local government has been innovative and has adapted in the face of severe cuts, and this is no less true for public health teams. The Public Health Grant is being used to strengthen a range of initiatives and services which promote prevention. To increase the reach of public health, teams are targeting resources informed by insight from lived experiences, communities and councillors. They are starting to generate revenues where there is an opportunity to do so. Yet this is not enough in itself to sustain non-statutory preventative work that can yield benefits in the long-term. As one expert reviewer of this report noted, the commercialisation examples discussed in this chapter are unlikely to be sufficient to match reductions in grant. Central government must show that it recognises the importance of resourcing public health.

4. ACHIEVING PREVENTION THROUGH STRONGER INTEGRATION

A shift upstream to address the wider determinants of health relies on integrated systems which are engaged with this goal. Currently, Health and Wellbeing Boards (HWBs) are the core mechanism to achieving this integration. However, as it stands, they do not appear to be set up to make a real change and they are not always addressing the issues that matter. Our survey showed that only 38.8 per cent of DsPH agreed their HWB was effective in addressing the wider determinants of health, and only 50 per cent of DsPH agreed that the Health and Wellbeing Strategy is fit for purpose to improve health outcomes locally. Our research also suggests they have not been able to influence key local structures such as STPs and devolution deals.

THE IMPACT OF HEALTH AND WELLBEING BOARDS

Health and Wellbeing Boards are vehicles for bringing local partners together, and for shared strategies for health and wellbeing between CCGs and local authority partners. They are one of the core mechanisms through which public health teams can engage with wider services. Established as part of the transition to local government in 2013, they require representation from the NHS, public health, adult social care and children's services, elected representatives, and the local Healthwatch.[49] Many boards also have representation from other local stakeholders, including the voluntary and community sector, wider public sector, and private sector.

Despite this broad representation on Health and Wellbeing Boards, only 38.8 per cent of DsPH agreed that their HWB was effective in addressing wider determinants of health. Many we interviewed felt that they lack the 'teeth' to make meaningful change and that there is a need for HWBs to be strongly resourced and empowered.

[49] Healthwatch represents people who use health and social care services.

"HWB as a body at the moment – it's just an information-giving type of thing…. I find a lot of the info is stuff I've seen before, heard before. Obviously, we need to fulfil our statutory obligations – but it's not used as effectively as it could be. It's treated like a scrutiny committee."
Healthwatch Representative

Some interviewees reported that HWBs are burdened with 'rubber stamping' activity, with few concrete resources to advance collaboration on addressing the wider determinants of health. Previous work has highlighted that the reason for poor integration of services and collaboration is the lack of movement towards stronger commitment, using so-called 'commitment devices' such as pooled budgets.[50]

When probed on why HWBs have not been effective in addressing the wider determinants of health, many interviewees said that they were dominated in content (if not representation) by matters of demand on NHS services. As interviewees noted:

"If the HWB wanted to improve economic health, how many conversations have we had with them about increasing job opportunities, post-16 learning etc.? None. All energy still goes into primary care discussions."
Local Government Officer

"HWBs are strange beasts — they are subcommittees of the council but are NHS dominated." **Director of Public Health**

The HWB has become the overseer of health and social care integration, an agenda which itself is increasingly focused on delayed transfers of care (DTOCs). The governance of the Better Care Fund (BCF) goes through HWBs. The BCF encourages integration by requiring CCGs and local authorities to set joint outcomes, and ultimately engage in pooled budget arrangements through an integrated spending plan. However, the BCF is not necessarily focused on long-term prevention, and research has noted the 'tension' between the HWB duty to integrate health and care and longer-term prevention initiatives.[51] More

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50 The Place-Based Health Commission (2016) Get well soon: Reimagining place-based health. NLGN and Collaborate.

51 Hunter, D. et al (2015). Evaluating the leadership role of health and wellbeing boards.

recently, central government requirements around the BCF have introduced targets to reduce DTOCs, reducing the resources for work that would stop people going into hospital in the first place.[52]

There was also some suggestion that a power dynamic held HWBs back from truly embracing prevention, due perhaps to a lack of confidence to put a counterview to healthcare partners:

"[Local government] aren't positioned to challenge it – so the diseased lifestyles approach continues." **Public Health Officer**

Our research suggests that Health and Wellbeing Boards need more powers and resources and are dominated by discussions around hospital use. Thus, while they do represent stakeholders of the wider determinants of health, 53.8 per cent of directors of public health agreed there is still a lack of clear system leadership on the wider determinants of health. However, when the future of HWBs was raised at a roundtable, attendees felt that scrapping them would be throwing the baby out with the bathwater: "*they may not be perfect but we need to consider what the direction of travel is.*" Instead, they need to be empowered and resourced to effectively tackle the wider determinants of health and achieve long-term prevention.

ENGAGEMENT WITH OTHER LOCAL STRUCTURES

Stronger HWBs would be able to put long-term prevention 'on the map' and influence local policy structures such as STPs and new combined authorities. Equally, these structures need to recognise the relevance of public health to their work.

ENGAGEMENT WITH HEALTH

Now that most public health functions do not sit in the NHS, it is even more important that the NHS grasps its own role in prevention, as an employer and also a part of local systems. One DPH said that they saw the lack of focus on prevention in the NHS more clearly now that they worked in local government:

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52 LGA (2017). Better Care Fund July Guidance – Frequently Asked Questions

"They fix one problem and as soon as someone goes out of the door, they forget all of the things that brought them there!" **Director of Public Health**

This issue came to light with regard to STPs. Public health's engagement with STPs has been patchy, and several Health and Wellbeing Boards had not been consulted on STP plans. Issues of capacity and boundaries that are not coterminous meant that some teams felt unable to develop the prevention angle of STPs as they would have liked. There was a sense across all those interviewed that the prevention strand of STPs:

"…focuses on secondary prevention and reducing the incidence and development of long-term conditions with immediate cost – things which reduce the immediate NHS cost within 1-2 years. We aren't in a Marmot-based view of the world – we're focusing on diabetes as a 'quick quick quick' process." **Local Government Officer**

A stronger influential role for public health would help STPs contribute more to real long-term prevention. For this to be achieved however, there is a need for stronger guidance on the benefits of STPs engaging with HWBs and the long-term prevention agenda. Research has suggested that as it stands, STPs are focused on short-term financial imperatives rather than plans for the future, and in most cases local authorities do not have a strong role.[53]

COMBINED AUTHORITIES

Despite being focused on long-term planning for key wider determinants such as the economy, housing, and transport, combined authorities were also not always recognised as a vehicle to achieve public health objectives.

"As a primary authority for economic growth, the combined authority is a big opportunity for addressing the wider determinants… but we haven't seen that as an explicit goal and some colleagues are nervous to make it such. We don't want 'mission creep' into blue light integration and health and social care integration." **Council Chief Executive**

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[53] Reform (2017). Saving STPs: Achieving meaningful health and social care reform

This was surprising, as many public health officers recognise that the focus of devolution deals is central to health: the local economy provides good jobs, transport can improve air quality, reduce exclusion from employment, and reduce isolation, and the supply of good quality affordable housing can prevent cardiovascular diseases, respiratory diseases and depression and anxiety.[54]

Given the complexity of existing devolution arrangements, a reluctance to introduce another voice into the process is understandable. However, as long-term plans are becoming established and embedded, the opportunity to build in health promotion and prevention of illness from the start should not be missed.

55 per cent of survey respondents from county councils thought devolved budgets for economy, skills and housing or benefits would increase their effectiveness in addressing the wider determinants of health locally. Currently, some of these areas are not sufficiently engaged with public health.

As we noted in Chapter 1, conversations about growth need to be more focused on reducing inequalities in health. As one roundtable participant suggested, shifting action about growth towards 'inclusive growth' may be one way to do this, and could draw on the foresight and data skills of public health teams:

"We need to ask – are 25,000 new jobs going to the people with the greatest need – and if not, how do we give them access to the job market? It's about being clear that we don't have exclusive ownership of the public health agenda, but we do have skills nobody else has, so let's focus on engaging with the system." **Senior Public Health Officer**

A supportive local policy context to address the wider determinants of health is progressing, but slowly. Health and Wellbeing Boards are varied in their effectiveness. As young institutions, they may need more time to become established, and increased resources to tackle the wider determinants of health. STPs could be a key space of opportunity for public health teams to have influence, but their prevention strand could be expanded. The opportunity to engage with these issues through combined authorities has also not yet been used to full effect. Local systems need to be engaged more strongly with the public health agenda, and stronger HWBs are a key way to achieve this.

54 Marmot et al (2010). Fair Society, Healthy Lives.

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

Our research has shown a clear need for public health to build stronger links with services which can promote good health and prevent poor health before it ever occurs. This is a precondition to creating a truly preventative system, in which existing resources and assets are geared towards addressing the wider determinants of health. We have identified a number of gaps in the system where public health needs to generate more impact, and suggest how this might be achieved in practice.

Public health has integrated well with local government, particularly with regards to people-based services such as social care. It is now in a good position to extend its reach and influence more fully the wider determinants of health.

RECOMMENDATIONS

AREAS FOR PUBLIC HEALTH TEAMS TO FOCUS ON

1. PUBLIC HEALTH TEAMS AND ECONOMIC DEVELOPMENT TEAMS SHOULD WORK MUCH MORE CLOSELY TOGETHER. THIS MUST BE BASED ON CLEAR RECOGNITION THAT GOOD HEALTH AND EMPLOYMENT ARE CLOSELY LINKED, AS ARE POOR HEALTH AND WORKLESSNESS.

Our health is strongly influenced by our work, yet the links that public health has with economic development departments and with local employers are comparatively weak. To achieve this in practice, we recommend:

- Public health teams need to strengthen their influence and relationships with local stakeholders which are responsible for growth and employment, such as economic development departments, local businesses, and Local Enterprise Partnerships.

- In turn, those responsible for developing growth strategies at local and sub-regional levels need to engage public health right from the start and proactively incorporate intelligence and input from public health teams.

- **We recommend that the future Industrial Strategy should have a clear focus on health, including explicitly recognising the public's health as an economic asset that contributes to growth, productivity and prosperity.** This would support local links between public health and local economic development. Economic development has traditionally been seen as focused primarily on hard infrastructure – this narrow focus needs to be challenged from the level of national strategy. Such a signal within the centrepiece of domestic economic renewal would catalyse the development of strong local relationships between public health and economic development in practice.

2. COLLABORATION ON PUBLIC HEALTH BETWEEN COUNTY AND DISTRICT COUNCILS SHOULD BE DEVELOPED.

Housing and planning are key partners for public health. We found these links were developing well in unitary authorities, but in two-tier areas where district councils have responsibility for housing and planning, there is a need for stronger collaborative links to be developed around the priority of public health, so that opportunities to improve public health using the full range of levers to address the wider determinants through the built environment are fully realised.

3. IN ORDER TO BETTER TARGET ACTIONS, PUBLIC HEALTH TEAMS NEED TO DEVELOP STRONGER RELATIONSHIPS WITH SERVICES WHICH ARE RESPONSIBLE FOR GROUPS FACING POOR HEALTH OUTCOMES.

For example, our research found that there is a clear opportunity to strengthen links with agencies in the criminal justice system, which will benefit the health of offenders and the communities they come from.

Extending the reach of public health will help to prevent poor health before it ever occurs and achieve healthier, longer lives for all. This is key to make

a real difference to the population's health and to sustain the future of public services.

There are barriers to achieving this ambitious vision for public health. Some of these barriers are within the power of local government to address, but some will need to be addressed by a national push to develop local capacity to achieve better health outcomes over the long-term.

OVERCOMING THE BARRIERS

1. HEALTH AND WELLBEING BOARDS (HWBs) ARE GIVEN THE POWER AND RESOURCE TO DRIVE FORWARD LONG-TERM PREVENTION INITIATIVES.

Throughout our research, we found that HWBs lack sufficient focus on addressing the wider determinants of health. In particular, we found that HWBs' agendas were dominated by issues around demand on hospitals; and that they lack sufficient capacity and powers to improve population health over the long-term. While stakeholders do not want them to be abolished, in their current form they risk being sidelined as a talking shop on the edge of the system rather than driving the system forward to address long-term, local population health needs. For example, HWBs tend to have little influence over Sustainability and Transformation Plans (STPs), and so the long-term prevention strand of STPs remains under-developed.

We believe that it is important to recognise the value of HWBs in bringing together key partners within the local system, beyond just health, and set out proposals by which this could happen in practice.

To ensure HWBs are able to improve long-term population health we recommend that:

- Central government should rewrite legislation to state that 'all local public services must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy in their area'. This would ensure that HWBs, and the strategies which they produce, are positioned to galvanise action across local systems on addressing the wider determinants of health.

■ NHS England should produce guidance that requires STPs to engage with HWBs on the wider determinants of health. Currently STPs focus strongly on internal integration within the NHS and with key partners such as social care. As these strategic partnerships mature, there is a need to engage with local health systems to take a longer term, preventative shift, for which HWBs should be recognised as a key enabler.

■ In order to pump-prime the capacity of HWBs to address the wider determinants of health across the local system, including areas such as economic development, central government can support this shift to working in a more networked way by investing £65 million in a 5-year pilot 'upstream prevention' programme.[55] This money would be used to:

■ Invest in innovative public health pilots that address the wider determinants of health within HWB areas;

■ Remunerate a support officer for the board to ensure that their work can be driven forward effectively. In two-tier areas the support officer's responsibilities would include specific responsibility for engaging district councils on the HWB.

2. PUBLIC HEALTH WORKFORCE DEVELOPMENT INCORPORATES THE NEED FOR 'SOFT SKILLS' AS WELL AS TECHNICAL SKILLS, TO ADAPT AND INFLUENCE WITHIN THE LOCAL GOVERNMENT ENVIRONMENT.

Our research found that the public health workforce recognises the need to develop certain soft skills: namely influencing and communication skills, and storytelling with data. These skills are important for engaging elected members and also other key local leaders who have a role to play in improving health.

■ To address this, we recommend that national bodies such as the Local Government Association facilitate regional peer-led training and development initiatives for public health teams on influencing and communications skills

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[55] Figure of £65 million assumes £100,000 each year over 5 years for 130 HWB areas.

3. TO EXTEND THE INFLUENCE OF PUBLIC HEALTH, COUNCILS SHOULD EMBED A CULTURE OF HEALTH IN ALL PRACTICE AND POLICY.

Developing a working culture that understands the relevance of health across the range of local government's responsibilities will be the most effective way to extend the influence of public health teams. There is not one single model for where public health should sit within a council; the priority is to ensure that public health influences the range of council activity and to foster a culture which recognises and values it both internally and externally.

■ Reflecting the need for public health to see its role as networking and enabling, teams should develop 'health champions' across local services who are already advocates for improving health and can promote public health initiatives among their peers.

■ Councils should regularly evaluate and reflect upon the impact of public health within a council's culture and practice. Where public health teams report to social care, it is important to review whether they are reaching out to economic development. This regular review would help provide a better understanding of how effectively public health teams have shifted towards addressing all of the wider determinants of health.

4. CENTRAL GOVERNMENT MUST SUPPORT LONG-TERM FUNDING FOR PREVENTATIVE INITIATIVES.

Local government finance faces continuing pressure and uncertainty in general, with reduced grant and lack of clarity over the future of business rates retention. Cuts have been made to the Public Health Grant and, while teams are considering how to maximise the resources available to them, this will not be sufficient to fund essential preventative work. We recommend that:

■ Central government clarify the funding and finance situation for local government in general, and public health in particular. If local partners are to make the investments required for good public health outcomes over a longer period, they require longer term certainty and assurance.

■ Local councils work with bodies such as Public Health England to develop approaches to evidencing the business case for investing in

public health over the long term, especially as public health extends its influence into new areas. This collaboration should help to support a shift towards new financing and local investment frameworks across multiple partners, that can make the shift towards a stronger preventative approach focused on the wider determinants of health in practice.

It has only been a few years since the transfer of public health teams to local government, and public health teams have made very encouraging progress. Now it is time for public health to extend its reach and address the full range of the wider determinants of health through tackling some of the gaps we have identified in their relationships. But for this to happen, the capacity of public health to influence a broad range of partners must be strengthened both locally and nationally.

APPENDIX 1: METHODOLOGY

The methods used to complete this report included a desk-based literature review, in-depth interviews, a workshop and a roundtable, three case studies, and three England-wide surveys of members, senior officers and directors of public health.

DESK-BASED RESEARCH

We reviewed approximately 25 documents, ranging from academic papers, policy documents, to third sector research papers. This literature review was not systematic but provided us with a contextual background on the current state of public health in England and the existing challenges that public health practitioners are regularly facing. Themes emerging from the literature review were used to shape our field research.

DATA ANALYSIS

Additionally, we conducted secondary analysis of datasets on a range of topics, including public health outcomes, local government finances and socio-economic indicators of wider determinants of health. Our analyses were based on official databases from a number of sources including the Department for Communities and Local Government (DCLG), the National Audit Office (NAO), Office for National Statistics (ONS), Department of Health (DoH) and Public Health England (PHE). This secondary analysis allowed us to develop a more holistic understanding of the context surrounding the challenges faced by public health teams.

INTERVIEWS

Between April and September 2017, we carried out in-depth, stand-alone interviews with nine participants including directors of public health, junior public health officers, a district council officer and a senior officer in strategy. These were largely recruited through our membership network

of councils. These were carried out in addition to interviews with case study participants (detailed below). Data from interviews was analysed thematically. All quotes from the interviews which are included in the report have been anonymised for the purpose of the research.

WORKSHOP

We conducted a workshop on 23rd May 2017 in London. This workshop kicked off the research by engaging 40 directors of public health, senior council officers and voluntary sector organisations in debates about the ongoing challenges since the transfer of public health to local authorities. The workshop explored major challenges that councils faced in shifting the focus of public health to prevention, including the issues surrounding collaboration and capacity. The findings that emerged from this workshop were subsequently used to inform the design of the survey questionnaires.

SURVEYS

We designed and distributed three separate surveys targeting distinct groups of people (directors of public health, members and officers) based on their different levels of involvement within public health. The survey for directors of public health was open to directors of public health and senior public health officers (abbreviated throughout as DsPH respondents). The officers' survey and elected members' survey were aimed at a deliberately broad audience to test understanding and influence of public health across a broad range of council departments. Where relevant and appropriate, the same questions were posed across the three surveys to enable comparison. The surveys were open from May to October 2017, for 16 weeks in total. Further details about the survey can be found in Appendix 2.

CASE STUDIES

A 'longlist' of potential case studies was initially produced using insight from our early survey responses and knowledge from early interviews and literature review. We then shortlisted the potential case studies to ensure a good balance between geographical locations, type of council and size of

council. The case studies were also selected to correspond to early themes emerging from our interviews and literature review.

The three case studies selected were Devon County Council, Camden and Islington Councils, and Darlington Council, which represented three local authority types (a metropolitan borough, a county council and a London borough), in three regions of the country (North East, South West and South East). The sites selected also foreground three different approaches to public health integration, in geographical areas with very different population needs. Case studies were carried out through in-person interviews with officers across the councils, elected members, Healthwatch and local VCS organisations. They were supplemented with publicly available data and documents.

Between August and September 2017, we carried out in-depth interviews with over 40 stakeholders in Devon County Council, Camden and Islington and Darlington Council. We spoke to 14 individuals in Devon County Council as well as a focus group with a district council, 7 in Camden and Islington, and 16 in Darlington. The case study interviewees were selected to ensure representation of public health practitioners, chief executives and elected members, services which affect the wider determinants of health, and Healthwatch and VCS representatives. All quotes from the interviews which are included in the report have been anonymised for the purpose of the research.

ROUNDTABLE

We organised and conducted a roundtable towards the end of the research project, on 28th September 2017 in Darlington. This roundtable was attended by 20 directors of public health, senior council officers, elected members and voluntary sector organisations. During this roundtable, participants actively contributed to discussions on the research findings and provided insightful feedback on our proposed recommendations, which were carefully considered as we finalised the report.

APPENDIX 2: ABOUT THE SURVEYS

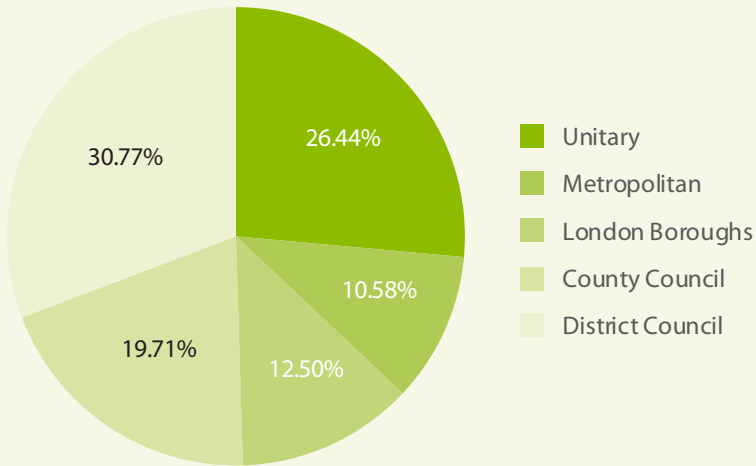We designed and distributed three surveys targeting specific groups of people based on their level of involvement within public health. We received over 400 survey responses from the three surveys: 99 from the survey for directors of public health, 227 from the officers' survey, and 92 from the members' survey. The type of authority and regions that respondents came from are summarised in the following charts.

FIGURE 9 SURVEY RESPONDENTS BY REGION (n=418)
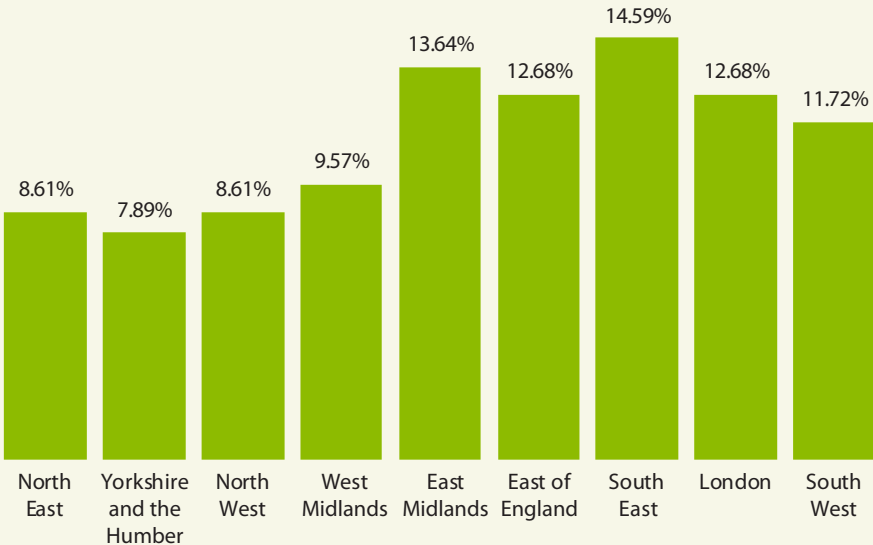
Overall, as shown in the chart above, the highest proportion of respondents came from the South East (14.6 per cent) and the East Midlands (13.6 per cent), and the lowest proportion of respondents came from Yorkshire and the Humber (7.9 per cent).

FIGURE 10 SURVEY RESPONDENTS BY TYPE OF LOCAL AUTHORITY (n=416)

- 26.44% — Unitary
- 10.58% — Metropolitan
- 12.50% — London Boroughs
- 19.71% — County Council
- 30.77% — District Council

The highest proportion of respondents came from district councils (30.8 per cent), followed by unitary councils (26.4 per cent) and county councils (19.7 per cent). The chart below shows that a majority (60 per cent) of our survey respondents were officers including some front-line staff. This is followed by members at 19 per cent and directors of public health at 12 per cent.

FIGURE 11 SURVEY RESPONDENTS BY ROLE (n=414)

- 12% — DsPH
- 60% — Officers
- 19% — Members
- 9% — Other
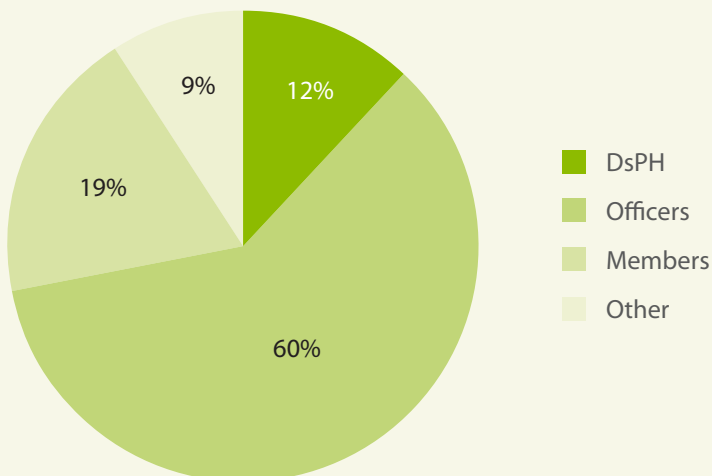
The results from the three separate surveys were collated and the quantitative data analysed using Microsoft Excel. Selected charts and graphs have been included throughout the main body of this report as relevant.

In addition to quantitative data, qualitative data collected through the surveys were extracted and analysed thematically to inform the overall research. Where relevant, we have included some quotes obtained from the surveys in the report, and they too have been anonymised for the purpose of the research.

APPENDIX 3: CASE STUDIES

CASE STUDY 1: CAMDEN AND ISLINGTON COUNCILS
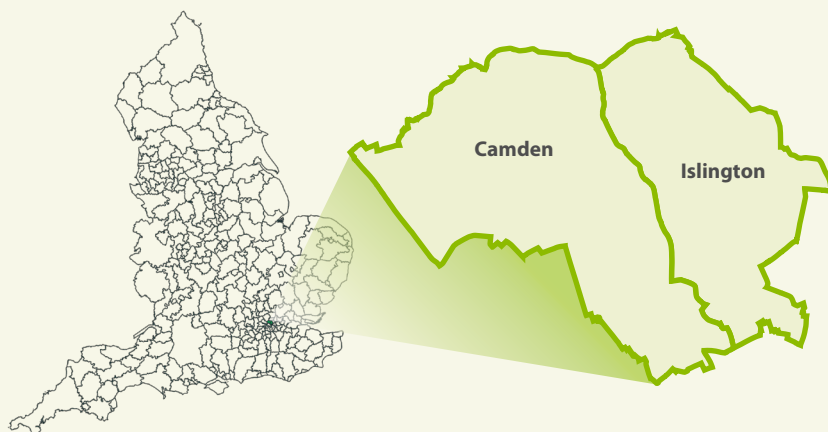
Camden and Islington are Inner North London boroughs, with respective resident populations of 241,100 and 232,400.[56] The two local authorities have a shared Public Health Service, with one joint Director of Public Health. The shared service endeavours to work in a flexible and integrated way across the two boroughs, enabling an exchange of insights, learning and approaches, as well as jointly commissioning and delivering public health services where it makes sense to do so. As a larger joint team, the service has retained key specialist public health skillsets and expertise, which is deployed across both councils and local strategic partnerships.

The public health team's focus on improving population health and wellbeing outcomes and reducing inequality is closely aligned to wider corporate priorities in both councils, and the team takes an opportunistic approach towards driving a focus on health outcomes within wider council strategic priorities and agendas, in order to build political support and influence. Resident, user and community participation and co-production are also key features of public health strategies and programmes in the two boroughs,
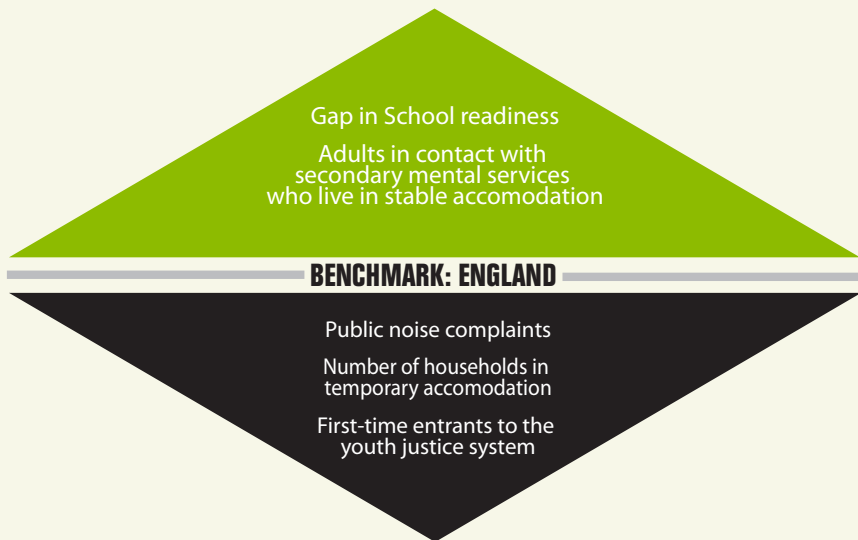
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[56] See Islington Joint Strategic Needs Assessment and Camden Joint Strategic Needs Assessment

with initiatives such as the Community Researcher programme helping to ensure services are citizen-centred, with a particular focus on residents and users experiencing inequality and poorer outcomes.
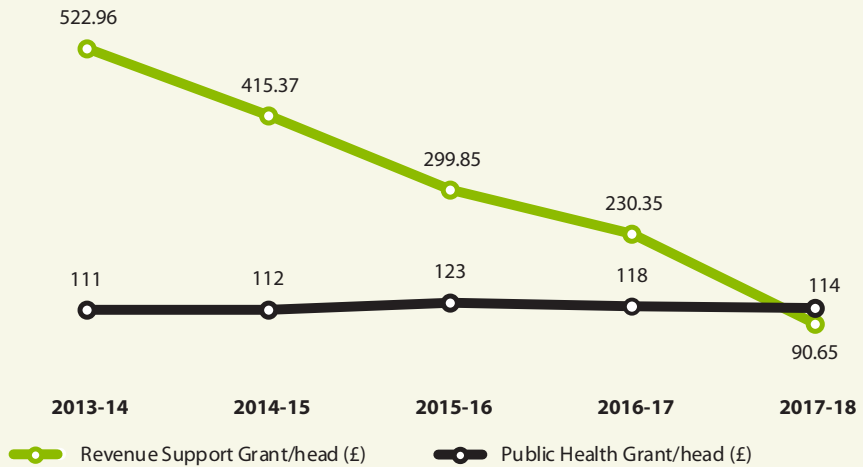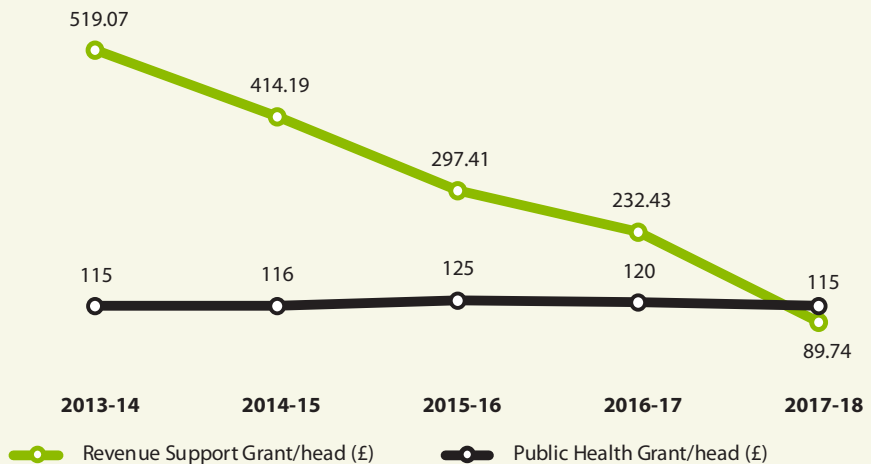
CONTEXT

Local authorities are facing financial adversity. As Figures 13 and 14 demonstrate, the Revenue Support Grant for both Camden and Islington Councils has been reduced year-on-year.[57] For both boroughs, the 2017-18 Revenue Support Grant per head stands at less than one fifth of the 2013-14 grant. Although it appears that the Public Health Grant has remained relatively stable, this does not take account of the fact that the grant increase in October 2015 coincided with the transfer of 0-5 public health nursing services from NHS England, which disguised the four-year programme of national public health cuts. This overall reduction has necessarily affected the ability of local authorities to deliver preventive, non-statutory health improvement programmes.

FIGURE 12 HOW CAMDEN AND ISLINGTON PERFORM AGAINST THE BENCHMARK

Gap in School readiness

Adults in contact with secondary mental services who live in stable accomodation

BENCHMARK: ENGLAND

Public noise complaints

Number of households in temporary accomodation

First-time entrants to the youth justice system

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[57] Revenue Support Grant is being phased out as local authorities are expected to rely on other sources of income like Council Tax receipts and business rates, which are forecast to increase. For more details, see https://www.gov.uk/government/news/local-government-funding-at-the-spending-review-2015

FIGURE 13 PUBLIC HEALTH GRANT & REVENUE SUPPORT GRANT PER HEAD: CAMDEN

522.96
415.37
299.85
230.35
114
90.65

111
112
123
118

2013-14   2014-15   2015-16   2016-17   2017-18

Revenue Support Grant/head (£)   Public Health Grant/head (£)

FIGURE 14 PUBLIC HEALTH GRANT & REVENUE SUPPORT GRANT PER HEAD: ISLINGTON

519.07
414.19
297.41
232.43
115
89.74

115
116
125
120

2013-14   2014-15   2015-16   2016-17   2017-18

Revenue Support Grant/head (£)   Public Health Grant/head (£)

PRIORITIES

Whilst each borough maintains its own Health and Wellbeing Strategy and priorities focused on the needs of their own populations, there is considerable synergy between the two boroughs in terms of population health needs, issues and priorities. In both boroughs, the overarching focus is on reducing health inequalities and ensuring no-one is left behind, with action oriented towards prevention, early intervention and building individual, family and community resilience. The importance of action on the wider social, economic and environmental determinants of health underpins local public health and whole council strategies to improve health and wellbeing, responding to high levels of child poverty, worklessness, in-work poverty and overcrowding.[58]

Mental health is also a shared public health priority across both boroughs, with high levels of mental health need. For example, Islington experiences the highest rate of diagnosed depression and anxiety of any London borough, and the prevalence of mental health disorders in children and young people in Camden is a third higher than the national average.

WORK AND WELLBEING

Worklessness substantially contributes to health inequalities in Islington. Islington has one of the highest rate of claims for Employment and Support Allowance (ESA) or Incapacity Benefit (IB) of any London borough. More than half of local people claiming these benefits do so primarily due to a 'mental or behavioural disorder', while slightly under half are claiming benefits primarily due to a physical health condition or disability.

In 2014, Islington Council established an Employment Commission in order to understand the nature of unemployment in Islington and what could be done to reduce it to the lowest possible level and to keep it there. In the evidence presented to the Commission, public health made a strong case for focusing on health and employment.

[58] Islington Joint Strategic Needs Assessment and Camden Joint Strategic Needs Assessment

As a result, the Islington Wellbeing and Work Partnership was set up and chaired jointly by the Director of Public Health and an Executive Director from Islington CCG. The partnership brings together senior representatives from the council, CCG, NHS providers, Jobcentre Plus, and experts by experience, with the aim of improving employment and health outcomes for local residents with a long-term health condition or disability and those at risk of long-term sickness absence. The partnership recognises that health-related unemployment is a complex issue, for which there are no quick or simple solutions, and is developing and testing a range of approaches, including developing, testing and learning from new types of employment support; awareness raising amongst health care professionals and employment coaches of the links between work and wellbeing; improving referral processes and the quality of employment support services; and engaging local employers to support and recruit staff with physical and mental disabilities alongside promoting workplace wellbeing.

Working with a national charity, the Shaw Trust, the partnership is currently piloting a local approach to supporting residents who have been given a fit-note by their GP, providing them with the support they need to get back to work sooner and to prevent long-term sick absence. The partnership is also working with NHS England to implement and evaluate the 'hard wiring' of employment support into primary and community care settings, through the Islington supported employment trial.

Both Islington and Camden Councils recognise the importance of the workplace as a setting for improving and promoting people's health and wellbeing. The London Healthy Workplace Charter was designed to support employers to address workplace wellbeing. Employers are assessed on their commitment to improving employee health under a three-tier rewards system. Participating workplaces receive free training courses, template policies and support with setting up wellbeing activities such as a physical activity clubs. Camden and Islington's public health team work with the economic development teams in both councils to engage with local employer networks to promote the charter and encourage take up. Thus far, 30 businesses across Camden and Islington have achieved or are working towards Charter accreditation. Recognising the critical role that good employment has on wellbeing, the public health team has successfully enhanced the

understanding of the impact of employment on health locally and has helped to build partnerships to integrate the health and employment agendas.

HEALTHY WEIGHT, HEALTHY LIVES

Healthy Weight, Healthy Lives (HWHL) is one of five priorities within Camden's Health and Wellbeing Strategy 2016-18: Living Well, Working Together. This priority clearly recognises the complexity of excess weight and obesity as a public health challenge, and the multiple, interrelated factors at individual, community and population levels that influence weight. This means looking beyond individual diet and physical activity to understand how physical, economic and social environments influence and shape behaviour, and exploring collaborative action to positively influence these drivers and determinants.

Taking a whole systems approach, public health has established two interrelated partnerships in Camden. These are the borough-wide Healthy Weight, Healthy Lives (HWHL) Partnership and the ward level St Pancras & Somers Town (SPST) Partnership.

PARTNERSHIP APPROACHES: HEALTHY WEIGHT, HEALTHY LIVES PARTNERSHIP

The HWHL Partnership is a collective of senior leaders from across Camden, including the council, schools, businesses, voluntary sector organisations and NHS trusts. The group provides leadership and direction across the Healthy Weight, Healthy Lives agenda, working with and through the people and organisations in Camden who are able to influence a greater number of Camden residents, thereby amplifying the reach and impact of the Partnership. The group has created an umbrella brand 'Camden Can' to bring together all of the activity currently happening in the borough to tackle overweight and obesity. Two current work streams being taken forward under the 'Camden Can' umbrella are The Camden Can Pledge and the Camden Can Innovation Fund. The Camden Can Pledge is a set of promises made by any organisation, business or group in Camden to make some simple changes that will help people who live and work in Camden lead healthier lives. The Camden Can Innovation Fund is a small grants

programme that funds local groups to find innovative ways of tackling some of the complex issues behind obesity in Camden.

PARTNERSHIP APPROACHES: ST PANCRAS AND SOMERS TOWN (SPST) PARTNERSHIP

The SPST Partnership is being delivered in the St Pancras and Somers Town ward of Camden between October 2016 – October 2019. It harnesses strong stakeholder involvement from a range of sectors including the council, VCS organisations, businesses, and health sector and community leaders, taking a highly local and context-specific approach to obesity prevention. There are two main objectives under the partnership:

1. To work with the community and wider stakeholders to develop insight into the drivers of obesity in the local area.

2. To use this insight to develop a series of initiatives that address key barriers to healthy eating and physical activity.

To date, the partnership has conducted extensive engagement work with a broad range of stakeholders, resulting an insight report that highlights key findings and recommendations for action. This report forms the framework for co-developing and co-delivering initiatives through the partnership, with several initiatives currently being developed and additional initiatives to be added over the subsequent two years of delivery. Examples of some of the opportunities that the partnerships have identified include:

■ Improving the availability and affordability of healthy fresh produce in the ward.

■ Improving the healthiness of existing food and catering outlets, including fast food outlets, in the ward.

■ Improving the availability of healthy alternatives to unhealthy snack or junk food consumed by pupils outside of school hours (i.e. to and from school).

■ Addressing the perception that healthy food has to be expensive and improving knowledge about ways to eat healthily on a budget.

LESSONS LEARNED

■ Developing trust and stakeholder relationships takes time – and support from senior leaders is key when moving from registering and galvanising interest in an approach to taking action.

■ Constant reflection and adaptation is key – both these partnerships are about using and testing new, innovative approaches to tackling longstanding and complex issues, such as obesity and health-related unemployment. Therefore, flexibility and the ability to respond to learning throughout delivery is important.

■ Whole-system and place-based approaches, involving multiple actors and agencies, are crucial to addressing complex issues, and for building partnerships committed to realising benefits over the long-term through a focus on prevention and early intervention.

■ Identifying missed opportunities and potential levers between existing services can enable local authorities to reach out to underserved groups, and maximise resources.

■ Using community expertise and co-production in service design and delivery ensures services are locally appropriate, well-utilised and responsive to changing needs.

CASE STUDY 2: DARLINGTON COUNCIL
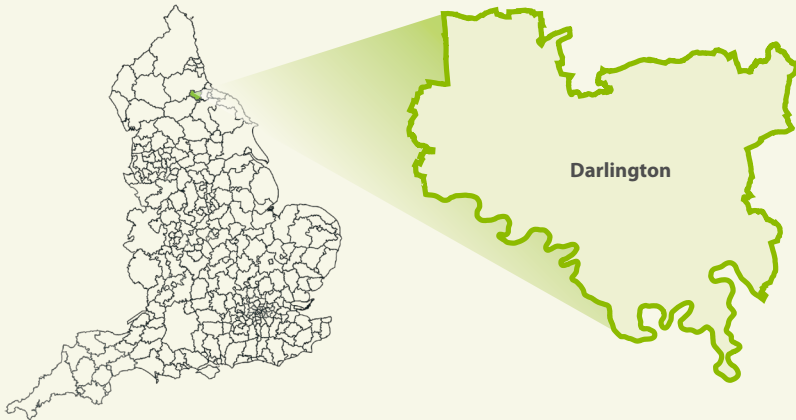
Darlington is a large town and unitary authority in the North East of England, with a population of around 106,000.[59] The small size of Darlington Council enables close-knit working across departments, and officers have access to senior members of staff without facing layers of bureaucracy. Developing strong relationships and effective techniques to engagement is fundamental to the public health team's influence of wider stakeholders. Internal public health influence occurs through the Chief Officers Board, which meets fortnightly, as well as regular 'ad hoc' conversations that may not be as possible in larger, dispersed local authorities.

CONTEXT

Local authorities, including Darlington, are facing financial adversity. As Figure 16 demonstrates, the Revenue Support Grant for Darlington has been reduced year-on-year. The 2017-18 Revenue Support Grant per head now stands at less than a third of the 2013-14 budget. Whilst the Public Health Grant has remained relatively stable, having increased slightly since 2014-15, this does not take account of the transfer of 0-5 public health nursing services from NHS England in 2015, and associated grant increase. The significant overall reduction has affected the ability of local authorities to deliver non-statutory, preventative services that can improve health outcomes.

59 Public Health England, (2016). Darlington Health Profile 2016.

FIGURE 15 HOW DARLINGTON COUNCIL PERFORMS AGAINST THE BENCHMARK

Killed and seriously injured (KSI)
casualties on England's roads

BENCHMARK: ENGLAND

Children in low income families

Pupil absence
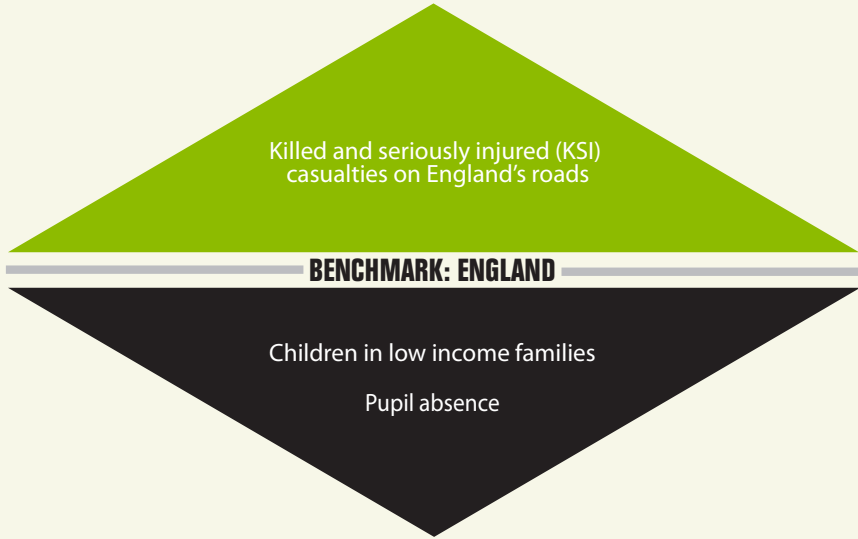
FIGURE 16 PUBLIC HEALTH GRANT & REVENUE SUPPORT GRANT PER HEAD: DARLINGTON

	2013-14	2014-15	2015-16	2016-17	2017-18
Revenue Support Grant/head (£)	285.39	234.70	169.91	125.64	85.86
Public Health Grant/head (£)	66	67	86	84	82

● Revenue Support Grant/head (£)   ● Public Health Grant/head (£)
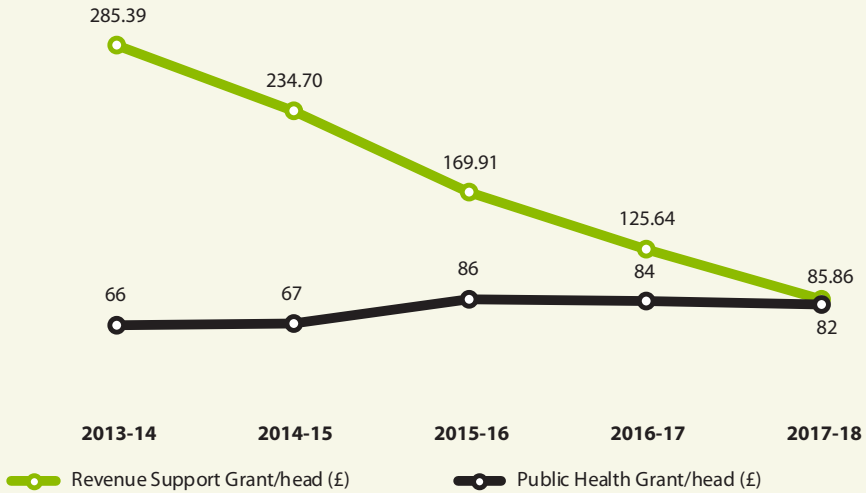
PRIORITIES

Darlington Council's current public health priorities include maternal and child health, addressing alcohol-relating injury and harm, raising the profile of mental health and wellbeing, and improving access to physical activity.[60] The public health team and wider council also recognise the importance of employment for good health. In particular, high youth unemployment rates mean that young people are susceptible to poorer wellbeing, higher mental health problems and low aspirations. As a result, tackling unemployment rates and improving high-skilled work opportunities lie at the centre of the wellbeing strategy.

FOSTERING OWNERSHIP

As a small team of five staff, the public health team have sought to engage individuals who have close links into wider networks, to broaden their capacity. Championing individuals as public health ambassadors has meant offering training and collaboration opportunities to teams that may not otherwise have seen their contribution to health, such as HR, and guiding them through their own initiatives. This support has been offered externally and public health have worked with Darlington Clinical Commissioning Group to devise and provide local schools with training on mindfulness and wellbeing as part of the national goal[61] to protect and improve children and young people's mental health.[62]

Darlington Cares[63] is an umbrella partnership between local businesses as part of the Darlington Strategic Partnership, aimed at using corporate responsibility to address community need. Minded to Help was developed in partnership with public health and Darlington Cares and delivered a 'train the trainer' initiative, whereby employers share best-practice approaches to addressing mental health in the workplace. Successful policies and

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60 Davidson, M. (2016). Annual Report of the Director of Public Health Darlington 2016. Darlington Borough Council.

61 Department of Health (2015). Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing.

62 Darlington Borough Council (2016). Children and Young People's Mental Health and Wellbeing: Darlington Transformation Plan October 2016 Refresh.

63 Darlington Cares (2017). Darlington Cares: Bringing Business and Community Together.

procedures are exchanged, aimed at increasing the confidence of employers to address mental health needs in the workplace. The Darlington Cares board also brings together local businesses and major employers to address a dearth of highly-skilled employment opportunities for young people. The scheme has increased training pathways and apprenticeship opportunities for local young people, and has used staff volunteering days to link local charities with businesses. Public health occupies a monitoring and evaluation role within Darlington Cares, and are developing a 'train the trainer' scheme, whereby exemplar businesses offer mentoring and training to other businesses that are looking to get involved.

Elected members at Darlington Council feel that their unique position within the community is appreciated and utilised by the public health team. This has meant enabling members to be strong community advocates by introducing them to different elements of public health through training, information sharing and awareness raising. Drawing on local knowledge, this process has fostered ownership of the agenda among members who, "know their geography intimately", and have insights into local populations. An example can be seen in Politics and Pooches, where local councillors conduct dog-walking surgeries to encourage community participation alongside physical activity. Such schemes are fun, free, and set attainable positive examples for the wider community.

REACHING FURTHER

With a small public health team and declining resources, the team takes a relationship-based approach to public health, capitalising on existing service providers (such as schools and emergency services) to extend their influence and reach, through joint initiatives.

Ensuring the health and wellbeing of the school-age population is a public health priority in Darlington. PHSE (Personal, Health and Social Education) will not become mandatory in England until 2018. Despite this, the public health team are highly engaged with the design and delivery of PHSE curriculums. The Healthy Lifestyles survey is part of this approach. Using data skills, the Healthy Lifestyles survey is a social values survey which collates social attitudes of school children on issues such as alcohol and

drugs, sexual activity, and the media. The results highlight the discrepancy between young people's perceptions and reality of, for example, peer alcohol-consumption, using social norms to influence behaviour change.

To raise the profile of mental health and wellbeing in school settings, the public health team have sought to develop key contacts in influential sites across the borough, and have commissioned a Relationship Education and Sexual Health Coordinator as lead. Drawing on their specialist capacity regarding mental health, sexual exploitation and internet safety, the VCS and public health have co-designed several programmes and services. One innovative outcome of this collaboration is SELFIE[64], an educational resource designed by Rape Crisis to tackle the increasing violence experienced by young people in relationships. Darlington Council's sex and relationships programme demonstrates effective joint working that can provide practical tailored solutions for service providers and wider communities.

Another example of 'behind the scenes' influencing is found in collaboration of public health with the fire department. One of the key difficulties in addressing wider determinants is providing early interventions: accessing vulnerable populations, identifying need and providing suitable signposting. The fire service in Darlington complete a community safety check when entering homes. These checks involve observations and questions on overall wellbeing, including loneliness and alcohol consumption, addressing mental health and alcohol risk. Should fire staff identify social isolation they refer people into Age UK befriending and outreach services. Utilising existing trusted services has increased access to vulnerable homes, further embedding public health into the community.

Darlington Council also acknowledges the importance of housing to promoting good health. Darlington is one of ten NHS-funded Healthy New Town sites in England, seeking to build healthier communities through town planning and urban renewal. Considerable consultation has taken place on how to energise residents to think differently about health and wellbeing. A new outdoor gym and play area will provide free access to exercise for both adults and children, and a £1,000 Community Health Grant has been

64 RSACC, (2017). SELFIE: Sexualisation Exploitation Love Friendships Information Empowerment.

created, funding community-led social and physical activities, such as a shared allotment. Schools have played a large role, and children have been involved in the design of new benches to encourage physical activity.

LESSONS LEARNED

- In a small authority, structural integration appears less important than building good relationships, which in turn fosters strong co-working practices between departments.

- Offering capacity and skillsets to wider teams has fostered trust and close working relationships, which in turn have led to influence in wider areas.

- Key individuals can have a huge impact on the delivery of essential services in 'difficult to engage' institutions, such as academies. The buy-in of schools can enable engagement of trusted community champions such as teachers to spread information and encourage parental engagement, improving the wellbeing of teenagers and young people.

- Using existing services to deliver interventions with trusted community actors, such as the fire service, has increased access to vulnerable homes. This is particularly important given the prevalence of privately rented homes in Darlington.

CASE STUDY 3: DEVON COUNTY COUNCIL
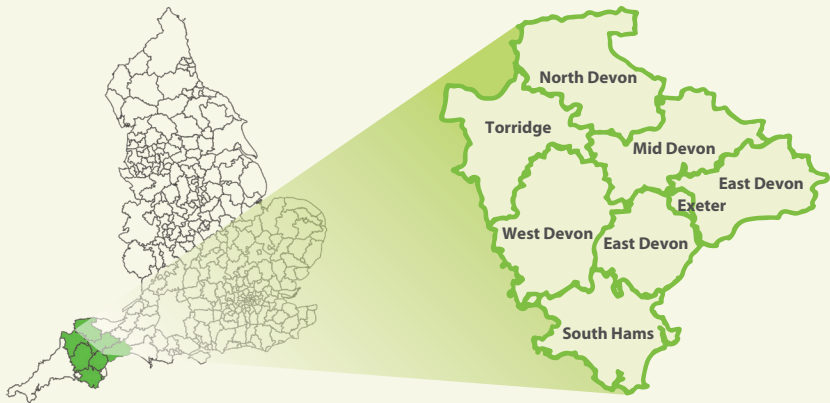
Devon is the third-largest county in England, covering 2,534 square miles, comprising one county council and eight district councils, including one city council. Devon has a dispersed rural population, and has faced cuts to the Public Health Grant. This increases the need to use public health resources smartly. Since the transfer of public health to local government, a distinct public health department was created, and existing roles and portfolios reshaped. Central to Devon Council's innovative strategy is the creation of a Director of Public Health role which has a Chief Officer function in relation to place-based functions and other areas of the council. This structure enables the fundamental principles of public health – intelligence, foresight and a population-based approach – to sit at the core of the Council's wider strategy.
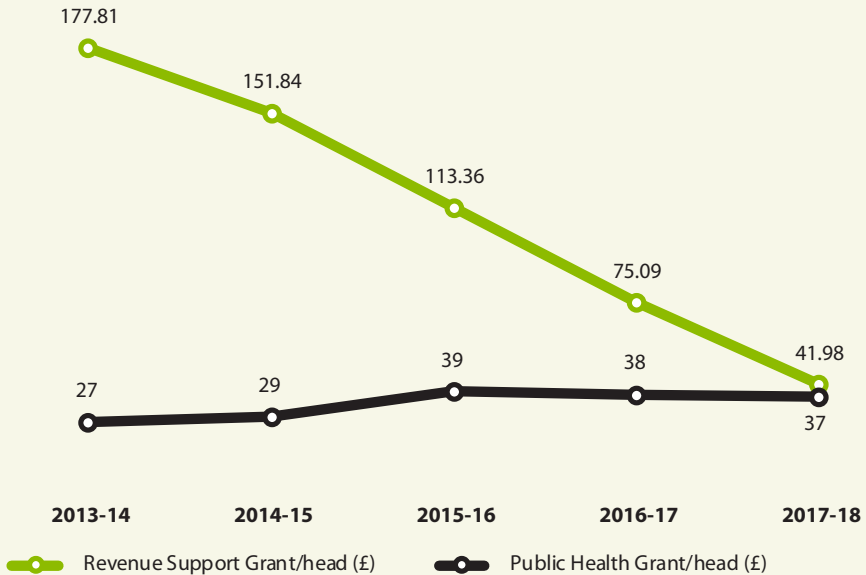
CONTEXT

Local authorities, including Devon, are facing financial adversity. As Figure 18 demonstrates, the Revenue Support Grant has been reduced year-on-year. The 2017-18 Revenue Support Grant per head now stands at less than a quarter of the 2013-14 budget. Although it appears that the Public Health Grant has remained relatively stable, this does not take account of the fact that the grant increase in October 2015 coincided with the transfer of 0-5 public health nursing services from NHS England, which disguised the four-year programme of public health cuts. This overall reduction has necessarily affected the ability of local authorities to deliver preventive, non-statutory health improvement programmes.

FIGURE 17 HOW DEVON COUNTY COUNCIL PERFORMS AGAINST THE BENCHMARK

Child health and education
Working age employment
Violent crime
Average life expectancy

BENCHMARK: ENGLAND

Employment rates for adults
with learning disabilities

Long-term health conditions and
mental health support needs

Road traffic casualties

FIGURE 18 PUBLIC HEALTH GRANT & REVENUE SUPPORT GRANT PER HEAD: DEVON

177.81

151.84

113.36

75.09

41.98

27   29   39   38
                                    37

2013-14   2014-15   2015-16   2016-17   2017-18

●——○ Revenue Support Grant/head (£)   ●——○ Public Health Grant/head (£)

APPENDIX 3: CASE STUDIES

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PRIORITIES

The vast geographical area and large rural population of Devon presents a unique set of public health obstacles. For 2016-17, the top five priorities are as follows: smoking, obesity and weight, poor dietary habits leading to physical and oral health problems, inactivity and lack of physical fitness and mental ill-health, poor emotional wellbeing and loneliness.[65]

FUTURE WORKFORCE

The Director of Public Health in Devon has a broad remit. As Chief Officer for Communities, Public Health, and Environment and Prosperity, the role oversees the place-based functions of communities, planning, transportation, environment, economy, enterprise and skills, as well as public health. Devised by the Chief Executive, this integrated approach maximises influence and strengthens relationships with officers and members. The DPH has a broad knowledge base of long-term planning and working with communities, and understands the pivotal role of the economy and environment on public health. Due to their broad approach to wider determinants, the public health team is also able to share skillsets across other teams in the council, for example by using intelligence to promote an evidence-based approach.

A key facet of the transition into local government from the NHS has involved adjusting to increased public accountability and political priorities from members. Nationally, public health teams have needed time to adjust to new working processes that consider local councillors. The public health team in Devon see elected members as an important resource, to enable public health to learn from and make the most of members' community connections. Personalising interventions is integral to building strong relationships with members. In practice, this means sharing health profiles from the Joint Strategic Needs Assessment at a local level, in relation to a range of issues. Transparency and honesty underlie member relationships with the DPH, and, as a result, elected members are increasingly advocating the wider contribution of public health.

[65] Devon County Council, (2016) Public Health Annual Report 2016-2017: Place-based Public Health. Exeter: Devon County Council.

MANAGING ADVERSITY AND FUTURE NEED

Local authorities are working hard to mitigate the impact of austerity on their service provision. A clear example of this can be seen with Devon's provider of library services, Libraries Unlimited, which, despite significant cuts to the libraries budget, has retained all 50 of its libraries. The core library offer includes a commitment to improving public health outcomes, including mental health. Working alongside public health, The Reading Agency devised Reading Well, which uses existing NHS prescribing services to recommend books to residents with long-term illnesses and poor mental health. Public health has used specialist data skills to conduct an impact evaluation of Reading Well, comparing uptake of the scheme to local prevalence of conditions by collating data on book withdrawals. Recommendations for population groups with high levels of anxiety, for example, are then used to build a more targeted service which is responsive to changing need. Reading Well has received national recognition, and take up is strong in areas with high prevalence of long-term conditions. Using a geographically-dispersed and universal service such as the library to deliver public health initiatives is one way of meeting the challenge of serving a rural population.

TAILORING INTERVENTIONS

Improving green infrastructure and access to outdoor space is crucial to Devon Council's strategy to reduce inactivity and improve physical fitness. Set up in 2012, *Natural Devon* is one of 48 Local Nature Partnerships aiming to promote, protect and improve the local green economy for recreation and physical activity. Research, public consultation and service design are the key tools used to activate this partnership.

Part of the green strategy includes the *Naturally Healthy* working group, bringing together environmental providers, park managers, and public health staff to enable cross-sector working and research on green infrastructure. This umbrella partnership model makes key local and national connections, promotes trailblazing ideas and liaises with existing service providers to share information and prevent replication.

Reconnecting Devon's people with nature is one of the partnership's aims, and public consultation is used to ensure the buy-in of local communities and enable behaviour change. The Devon Countryside Access Forum is a voluntary body seeking to improve public access to land for recreation. Meeting quarterly, the forum gathers public opinion on policies affecting access, to then advise the council. Forum members offer valuable insights on issues such as tourism, conservation and disability access.

In compiling a report about improving engagement and behaviour change in rural areas,[66] Natural Devon and Devon's public health team used data skills to identify geographical areas where communities were not accessing the countryside. The results prompted practical and sustainable solutions to reduce the limitations of rural transport for people from lower socio-economic groups or those for whom transport was a barrier to participation, enabling improved access to natural resources such as Dartmoor National Park. This enabling approach has also informed both Active Devon and Active Lives, two programmes which used detailed social marketing analyses, coming to very different solutions – with the latter developing a programme of social events anchored through the libraries service.

LESSONS LEARNED

- The seniority and breadth of responsibility of the Director of Public Health's role is a factor in creating influence for the public health team, and the broad responsibility of the role enables better strategic linkage across the council.

- Public engagement and evaluation is essential in understanding the different needs of local communities and therefore to developing sustainable solutions to behaviour change.

- Utilising existing systems, such as NHS prescribing, can enable the successful integration of the public health agenda, and foster geographically-targeted approaches to addressing long-term conditions and mental health needs. Examples of this can be seen in the Reading Well scheme.

66 Devon Local Nature Partnership, (2014). *Behaviour Change Scoping Report*. Exeter: Devon County Council.

THE HEALTH FOUNDATION

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen. We use what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

For more information, visit **www.health.org.uk/**

Prevention is fundamental to public health. The 2013 transfer of public health functions to local government was an opportunity for public health teams to influence the range of local services which affect the wider determinants of health: services like housing, planning and transport.

The transfer promised a shift towards stronger prevention and the closer coordination of existing resources to promote healthy outcomes. While the move has been largely successful, it has not been without its challenges.

This NLGN report focuses on the different ways in which public health is influencing the wider determinants of health, what the challenges are, and where there is potential to go further.

Supported by: