



# Towards a Healthy Democracy

An NLGN essay collection

Edited by **Simon Parker**



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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## *Foreword*

**This timely collection of essays squarely places public health back at the heart of local government, where of course, it has long belonged.**

Even more importantly, the essays are all written by council leaders; elected political leaders, who are reaching out to embrace the enhanced opportunities for improving the health of their populations contained within the Health and Social Care Act 2012. No room for the faint-hearted here. Without determined and enthusiastic local political leadership, not only might public health not flourish as it should, but local government would be shooting itself in the foot. Its core task, after all, is to improve the well-being of the local population.

The essays offer practical examples, not just stirring words, of what can be done to improve health, from councils at different tiers, and in very different parts of the country - but all determined to grasp the public health agenda.

“The future of public health and wellbeing lies firmly in the hands of local leadership”, says Cllr Keith Wakefield. Quite so.

**Dame Jane Roberts**

*Chair*

*NLGN*

## *Introduction*

**The return of public health to local government is probably the biggest single transfer of new responsibilities for decades. Many in the sector are justifiably excited by the change. Public health is much more than a question of providing specialist services: the task is to bring an active concern for health outcomes into the mainstream, across housing, planning, licensing and social care. Ultimately, it is about mobilising the whole council and many of its partners to create the conditions for the public to adopt healthier lifestyles.**

It is easy to focus on the structures and budgets associated with the new organisational architecture of health and wellbeing, but the debate really comes down to leadership. Officials have a huge role to play here, but in this collection we contend that promoting public health is fundamentally a political role. Only elected members have the legitimacy to stand on someone's doorstep and tell them why the council is reducing the speed limit to 20mph or campaigning for a minimum price of alcohol. Only the members can crack heads together in the town hall to ensure that transport planners recognise that public health is a core part of their job.

We have gathered together perspectives from six leading politicians across the country to understand how they plan to approach the new role. This is localism in action, so unsurprisingly the essays offer a wide variety of perspectives: from the district council which has no formal power, but has set up its own health and wellbeing partnership, to the city leaders looking to encourage the consumption of nutritious, locally-grown food.

Several of our politicians recognise the fact that the UK's current model for healthcare provision is fundamentally unsustainable. A system which focuses on treating illness cannot stand the test of an ageing population, so public health becomes a crucial way to keep people out of the system in the first place. As one contributor puts it, we will know that local government is succeeding when ministers start closing hospital beds not because of budget cuts, but because there is no longer any need for them.

Smoking, alcohol and diet all emerge as key themes throughout the collection. Our politicians are acutely aware of the danger of nanny-statism, but the boundaries of what constitutes nannying seem to be shifting. For instance, Newcastle’s residents seemed to instinctively welcome new powers to limit the spread of pubs and end the city’s reputation for hard partying.

The key to driving change may be a new kind of dialogue with residents which helps them understand the impact healthier lifestyles can have on their wellbeing, their local community and their wallets. That dialogue needs to be values that underpin a strong sense of local government’s role in public health. One of our contributors writes powerfully about the importance of compassion in the public health system, because health is a profoundly emotional issue and those who seek to lead on it have to see people as more than just statistics.

But what shines through most powerfully from all these essays is a deep enthusiasm for the new public health role. It is a commitment that burns across party lines. One of our Labour contributors makes the point that good public health services are a means to a fairer society, while one of our Conservatives sees public health as a way of making a permanent difference for his community.

Blaby’s Ernie White concludes with the rhetorical question: “Can local government do public health? You bet we can. You just watch!”

**Simon Parker**

*Director*

NLGN

# 1 *Leading change for better health*

## Cllr Nick Forbes

**I have pursued two of the most unpopular professions in our society – I’ve been an NHS manager and I’m now a politician. Both are careers viewed with the utmost suspicion by the majority of the public, who often have strong views on both. Yet having seen the world of health from several different perspectives – as an NHS insider and now as a community leader – I’m convinced that I can have more impact through politics and local government on the health of the population than I ever could working within the NHS.**

Part of the problem is that the NHS, much loved institution that it is, doesn’t exactly live up to its name. It’s not national, as there can be quite significant variation in the provision and quality of services around the country, and the vast bulk of its resources are directed to treating illness and disease, rather than promoting health. I’m less concerned about the first – after all, every area is different and it’s surely appropriate that resources should be directed towards need – but the second issue, that the ‘gravitational pull’ of large NHS providers swallows 98% of NHS budgets, is an imbalance that must be addressed if we are to tackle the challenge of increased demand and reduced resources.

As a result, I welcome the provisions of the Health and Social Care Act that transfers public health responsibilities to local authorities. Councils have a long history of taking action to improve public health. From the introduction of water and sanitation in the Victorian period, to the massive post-war house-building programmes; and from road safety measures to restaurant inspections. Many of the day-to-day activities of councils contribute to improving health.

Not everyone sees public health in this way, though. For many, it has become an important discipline in its own right, with professional accreditation and a clear career structure. This means that most councils, when getting to grips with public health, are being introduced to concepts such as contracts,

service delivery plans, national targets and TUPE staff transfer arrangements. There is a real danger that the minutiae of structural reform overshadows the fundamental purpose of realigning public health with local government – the opportunity to improve the quality of peoples’ lives.

It is an oft-cited urban myth that health isn’t a doorstep issue unless a hospital is under threat of closure. But while there’s no doubt that the withdrawal of services (particularly if they are based in a much-loved local building) is quick and easy fodder for signature gathering on petitions, to assume that people don’t care or aren’t interested in wider public health issues is to seriously underestimate the intelligence of local communities. This has been brought home to me time and again through the various public health campaigns I’ve been involved with during my time as a councillor. Here are three recent examples of public health campaigns from Newcastle where public support has been vital to their success.

The damage caused by smoking has been well-documented for more than half a century, yet it is only in the last decade or so that the UK has considered comprehensive tobacco control measures. Up until the introduction of the smoking ban, the common consensus was that smoking was a personal choice; however, the evidence and campaigning about the damage that second-hand smoke does to everyone who breathes it was pivotal in changing public attitudes. Although smoking kills more than 6 times more people in Newcastle than any other preventable cause of death, it has historically only been allocated 4% of NHS public health spending. What’s more, the bulk of this is funding for smoking cessation services – which are valuable and effective, but are powerless to prevent people from starting to smoke in the first place. This is a really powerful example of how the language of ‘prevention is better than cure’ does not fully match reality.

There are only three dedicated regional tobacco control offices in the UK (the North East, the North West and the South West) and cutbacks in Government funding have put the long term survival of these offices at risk. Tobacco control is a comprehensive approach to reducing the availability, affordability and desirability of tobacco products; this can only be done by forging partnerships across a range of professions and organisations. This includes employers, trade unions, trading standards, customs and excise, and health



charities. Our tobacco control work in the North East (I am proud to chair the Board that oversees the programme) has led to some phenomenal results – we have seen the steepest decline in smoking prevalence of any core city over the last year, a reduction in smoking of 5.6%. A huge part of the success have been our public information campaigns: *People Like Me* was an advertising campaign where ordinary members of the public spoke about the benefits of quitting; and *Take Seven Steps Out* reinforced the dangers of smoking at home in front of children. Our most recent campaign, in favour of plain tobacco packaging to help protect children from starting to smoke, has generated more than 10,000 responses to the national consultation – and since we started the programme in 2005, public attitudes have changed dramatically. Only 7 years ago, before the smoking ban, less than 50% of people thought that greater tobacco control measures were necessary – now 78% of the public think that we should do even more. On tobacco, we have sought not only to lead, but to change public opinion.

Over the last year, we have had a serious debate about alcohol policy. Once promoted proudly as a ‘party city’, the consequences of care-free drinking are starting to be all-too apparent. Longstanding concerns about anti-social behaviour in the city centre have been supplemented by alarming figures showing a huge increase in the number of people being treated for alcohol-related liver disease. For us, quite simply, the party’s over. Of even greater concern than the concentration of licensed pubs in the city centre is the explosion in off-licences in neighbourhoods around the city – and our mapping shows that the greatest concentrations are in the most deprived areas.

As a result, we have whole-heartedly campaigned for a minimum unit price for alcohol and are undertaking a comprehensive review of licensing policy to redress the balance. We have introduced a number of cumulative impact zones to protect communities already under the greatest pressure, and are lobbying the Government for the power to include the consideration of public health as a fifth licensing objective.

Far from an outraged public denouncing us as nanny state control freaks, we have been almost universally congratulated for this tougher approach. Residents have told us that, at last, they feel the Council takes their concerns about anti-social behaviour seriously. The Police have recognized that a

tougher licensing regime means less alcohol-related disorder, and health colleagues have pointed out that the year-on-year rise of alcohol-related hospital admissions has reached a plateau. Many pub and club owners have joined our call for a minimum alcohol price, as they recognize the damaging impact of people ‘pre-loading’ on cheap spirits before people come into town.

The third example of local public health action has been our work around introducing mandatory 20mph speed limits on all residential streets in the city. Driven by a desire to reduce the number of accidents involving children, particularly around schools, we rejected proposals for an advisory scheme (‘twenty’s plenty’) in favour of a legally enforceable one. Local residents have responded with enthusiasm: we are now receiving requests to increase the number of ‘play streets’, where traffic is banned altogether for particular periods of time. The reduction in traffic speeds is increasing road safety for motorists and cyclists as well as pedestrians.

These three examples have a number of common themes, which are particularly significant for the future role that councils will play in public health. First, each integrates a thematic issue across a number of areas of local government responsibility. The ability to be joined up, both within and between organisations, will be crucial to future areas of public health activity. Second, success from each has been achieved through a combination of enforcement and changing social norms. Simply telling people that there is a new rule in place is not sufficient, it needs to be self-enforcing, buying into the popular mood of the time. Often, change creates momentum for further change. Third, each has, in its own way, required political leadership – people who are prepared to speak out and stick to their points in the face of sometimes sustained hostility. Fourth, and linked to this point, each has a clear evidence base of effectiveness – those making the case for action can clearly point to reasons why it is needed. And fifth, each has prompted a high level of political debate, with local government playing a crucial role in promoting a clear and consistent set of proposals. These common themes are useful learning points for anyone considering how to ensure that councils make the most of the new public health powers and responsibilities, delivering a real and sustained step-change in the health outcomes for our communities.

## 2 *Stepping-up to the challenge*

### Cllr Catherine West

**On 1<sup>st</sup> April 2013, the responsibility for public health was transferred to local authorities. It represents a tough challenge, but it's an exciting one, and here in Islington I believe we're ready for it.**

As councillors, we're already on the front line providing the vital services on which many of our residents rely: the children's centres that help give our young people the best start in life; the home care and mental health support that are a lifeline to some of our most vulnerable adults; the boiler replacement and insulation programmes that keep our elderly residents warm and well. In Islington, we are one of only 22 local authorities in the country to still provide social care funding for those classified as having moderate needs.

We know that leading a local authority isn't just about overseeing services, it's about transforming lives. In Islington, we established a Fairness Commission in 2010, the first of its kind in the country, to look at how we could reduce inequality and create a fairer borough in the face of the biggest funding cuts since the Second World War.

Twenty cross-party, cross-sector commissioners were identified including councillors, the Chief Executive of the Primary Care Trust, the Police Borough Commander, the Head of the Islington Chamber of Commerce, representatives of the voluntary and community sector, and chair Professor Richard Wilkinson, co-author of *The Spirit Level*. The year-long listening exercise involved over 500 people and over a hundred written submissions were received. At the end of the process the commission came up with 19 radical yet realistic recommendations to make the borough a fairer place, including a commitment to the living wage, a new anti-social behaviour hotline and increasing mental health support.

Our commission looked at health, even though it didn't come under local authority control, because we already have to deal with the impact of health inequalities across everything we do. Men in Islington have the lowest life

expectancy in London and we have one of the highest levels of male suicide in the country. Our biggest killers are cardiovascular disease, cancer and chronic obstructive pulmonary disease; exacerbated by poor diet, lack of exercise, smoking and drinking. One particular problem we face is a high population turnover, in part because of the cost of housing. This means that in many cases no sooner have we found people and managed to get them appropriate treatment, they move on and another needy group move in.

With public health returning to local authority control, we will be able to do more than simply deal with the aftermath of conditions and instead work together with housing, education, social services and adult social care to prevent ill health, improve wellbeing and change behaviour.

In Islington in the 1930s, Finsbury Council took responsibility for local health and led the way clearing slums, helping to bring clean water and providing maternity services to local people. Local politicians have a history of championing and providing leadership across a range of subjects. Health has always been one of them, but we now have the added ability to focus our local priorities. This gives us much better opportunity to tackle the things that impact our residents most.

It means we can embed principles of public health across everything we do – which gives us much more influence. We know alcohol is a problem in Islington so we held an Alcohol Summit in September 2012 to bring together colleagues from public health, licensing and community safety. We've also given our Executive Member for Health the added responsibility for leisure, sports and arts – a change that sends a strong message to Council departments, partners and external stakeholders that our services are interlinked.

Health and wellbeing boards provide a new mechanism for increasing democratic involvement in the health and wellbeing agenda and a new platform for local politicians to provide leadership for public health. Quite simply, they help put the right people around the table – including politicians – so we can pull different strings and make change happen. During its shadow year, one of the priorities for our Board was the first 21 months of life, from conception through to the first birthday. We piloted antenatal

services in two of our children's centres, helped link new mothers to other mothers for advice and support, and used our Islington board to bring GPs into our children's centres in a way that hasn't happened before.

Locally, politicians can, and do, provide an understanding of the needs of local people, because we're out in the community every day talking to people and holding advice surgeries. This adds a richness of information and on the ground intelligence that can add power and legitimacy to the direction health and wellbeing boards take. Through our Board we're also seeing that local GPs face many of the same demands from those with health needs as we do – for example, they're now seeing a lot of people affected by the government's welfare reforms. We've been able to have early conversations about how we can link these people to council services, advice and support in a more joined up way – conversations that wouldn't necessarily have happened in the past.

But I'm very aware radical changes don't come without their challenges. What happens when we have to have difficult discussions on the reduction or closure of a service? However well-intentioned the decision making, these are always emotive and fiercely contested issues. As politicians, we're used to being on the frontline with our banners and our petitions. We will have to find ways through these dilemmas.

Similarly, as we set our priorities, how will we balance individual need with the wider health and well-being needs of our local population? Will we always be speaking the same language as the health professionals – and how well will they adapt to elected politicians getting involved more than ever before? This is a new way of working for politicians and GPs and we have to get the relationships right – the effectiveness of the boards depends on it, and the relationship between the Chair of the HWB and Chair of the CCG will also be extremely important.

But these are challenges we have to overcome because the opportunity to put in place a truly integrated system of public health is one we cannot let slip through our hands. I firmly believe that by working in partnership we can provide better services for our communities and that as politicians the local knowledge we bring to the table will be invaluable.

With our own budgets slashed over the last two years we are used to making difficult decisions and to working in a challenging financial environment. By working in partnership we will be better equipped to find ways in which we can save money, share resources without cutting frontline services and fight our corner against further funding cuts. Here in Islington, our intention is to run a shared public health service with our neighbours in Camden, and together we have appointed a Joint Director of Public Health to oversee our work in this area.

Sharing services makes sense. It reduces duplication and saves money at a time when all local authorities are feeling the pain of massive government cuts. But it's more than that. Camden shares many of the same challenges as Islington, from high levels of childhood obesity and smoking-related deaths to higher than average levels of drug misuse and lower life expectancies in the more deprived parts of our boroughs. We have already worked with our neighbours on joint projects, but this innovative plan – one of the first of its kind in the country – means we can develop and deliver a joint vision for health improvement that will help prevent poor health conditions and intervene early to the benefit of all our residents.

We mustn't be daunted by the scale of the change that lies ahead. The transition of public health into local authorities presents an opportunity to go beyond a transfer of resources and responsibilities, to transform the way in which inequalities are approached, and to create a shared understanding of the challenges faced across the health and social care system. In Islington, we are ready for the challenge.

### 3 *The 3C's of health and wellbeing*

#### Cllr Dean Russell

**For many district councillors, a key ambition is to make a permanent difference. However, at times this aspiration can feel distant, especially when reflecting on the complexity of local government and its various tiers of responsibility.**

This could not be any more apparent than when considering the challenge of health and wellbeing at a district council level. There are virtually no powers, budget or direct responsibilities. Yet district councils are ultimately closer to local people than both county councils and government, often managing the very aspects that have the most impact on the daily lives of residents. At the same time, most of the public do not distinguish between the tiers of government, so that clarifying the relationships of local power often sounds like 'passing the buck'.

Despite these complications, the idea of 'wellbeing' opens up a huge opportunity for district councils to fully engage the public and make a difference. After all, the wellbeing of residents is one of the areas on which district councils often have a huge impact: housing, planning and managing the local environment all affect residents emotionally, mentally and physically. So when health and wellbeing boards were announced at county council level, it created an exciting opportunity for district councils to re-evaluate their strategy for health.

In St Albans, we grasped the opportunity. Using this as a catalyst, we moved away from a quarterly community health committee – which had very limited ability to make an impact – and merged with the local Older People and Healthier Communities Partnership. By bringing these two committees together, we saw a chance to deliver a more focussed and practical approach, to reduce duplication of discussions and to become more than the sum of our parts.

We named our new approach the 'Health and Wellbeing Partnership' – with *partnership* being the operative word. Along with councillors, the membership

terms of reference were adjusted to include senior representatives from local NHS Trusts, GPs, county, district and parish councils and health bodies, patient and health watch and volunteering groups. In principle, we needed to create a forum where the right people could discuss real local issues and work together to solve them, not just point the finger of blame.

Of course, the changes at county council level brought no specific new powers for district councils other than the wider welcomed pressure of increased localism. However, I am a strong believer that a lack of power does not remove the responsibility. Creating a membership of people with insights around local issues and those with the power in their own sphere of expertise to make a difference would ultimately provide the district with a much stronger voice in the ever changing health landscape.

As chairman, I was also keen to build some founding principles beyond the terms of reference alone. These were compassion, collaboration and communication. These three C's are the DNA of my approach to the partnership and key, in my view, to successful local government.

So why consider 'compassion' as a principal component of the partnership? This is surely not a word that springs to mind when thinking about local government? Yet, surely compassion must be a central principle in our methodology; especially when discussing health and wellbeing.

After all health and wellbeing are not abstract matters for individuals. They have a wide-ranging impact on people's lives. For example, medically speaking a broken arm is nothing more than a fractured bone; a few hours in hospital and a few more check-ups. However for the individual it can reduce their ability to work effectively, it can cause sleepless nights, an inability to pick up their child or play sports to stay fit. Ultimately, it can create a raft of wellbeing issues beyond the relatively minor health one.

Without understanding the knock-on effects of health issues and the wider context on the individual, we reduce the public to mere numbers, into data to be processed rather than lives to be improved. In other words, the issues of health and wellbeing can be deeply personal - we must never forget this.



Compassion is not some fluffy immeasurable objective. It is crucial in creating understanding and building trust between people and politicians at all levels. In the health arena this is needed now more than ever. For many years, the press has published 'scare' stories around the NHS, from lack of cleanliness to funding to fears around privatisation. Whether we agree with the truth in the reports themselves is irrelevant. True or not, we can't ignore the impact of this message on everyday people.

The knock-on effect is that the general public are naturally going to have very real concerns about the care they receive and their ability to trust politicians' promises, whether there is a basis for their concern or not. The health of oneself or a loved one is one of the most personal issues one could deal with.

Let's face it - why would anyone feel comfortable believing any politician's promises about health in an age where the national trust of politics in general is at an all-time low? Without showing compassion and delivering policies which have compassion at their core, how can we ever rebuild trust?

This is why collaborating, and working as a true partnership is so important. An isolationist approach can often lead to buck passing, attempts to highlight failings of others and, at the extreme, attempts to hide issues. True partners understand the challenges and aren't afraid of sharing their mistakes, with the knowledge that they will be supported to solve them.

Having sat on several scrutiny committees, I can't deny feeling at times that the nature of some council meetings can be too one-way – especially in the health arena. For example, discussions around the rising crisis of obesity and the pressure this puts on the NHS can so often be followed by finger pointing that the NHS isn't doing its job right.

In our St Albans Health and Wellbeing Partnership, such a discussion around obesity would be much more likely to lead to a genuine debate (for example around the need for councils to increase outdoor park space for exercise) between all partners, not simply shifting the blame to the 'health professionals'. In other words, 'we are in this together', striving to do more than the basics. The single most important element of our commitment to partnership has been the set-up of three task and finish groups; focused on Obesity, Mental

Health and Alcohol Related Harm. These groups are made up of partners but can include other relevant experts. Their purpose is to identify and carry out the actions required to create measurable improvements. In some instances this could be as simple as working across organisational borders to identify if the right data exists to understand the problem fully. In other cases, their role may be to plan and follow-up on specific actions in locations where figures indicate health and wellbeing issues.

Of course, I don't want to pretend we are living in some dreamworld. There are some substantial economic challenges; the kind of pressure that could easily lead to divisions and protectionism. The creaking machine of local government and the NHS just aren't created to reward sharing. So it is an on-going study to see how this works long term – but one I am certain we will find some glimmer of hope in.

Getting this collaboration right is where communication becomes so important. It is no good simply requesting that people join a new partnership anonymously. I visited the partners before the first partnership meeting to understand their challenges and explain what we were trying to achieve and have endeavoured to maintain communications where possible.

This has been useful within local government tiers too. For example, creating opportunities for conversations with Hertfordshire County Council where we have had very positive support. In fact, we are particularly honoured that the Chair of the Hertfordshire Health and Wellbeing Board is a member too; something we could not have been able to achieve previously.

This approach to communication can be the thin line between success and failure. Without personal buy-in it is difficult to request individuals to go above and beyond. This includes working across party lines, which I am glad to say we have not suffered from due to being open and having regular communication wherever possible.

This is very different from *communications* though – where press releases flow in order to spread the word of success. In the sphere of politics, I have watched PR campaigns be used badly - with false promises and setting impossible expectation leading to trust ebbing away over the years.

Politicians can be far too quick to hype potential successes or promise 'change' before the system is truly ready. Understandable perhaps, considering the modern nature of popularity politics and the natural cycle of elections. It is ultimately self-defeating in the mid-long term as the public aren't fools. They are savvy enough to spot bravado and self-promotion, especially when they don't see any difference on the ground.

For this reason I purposefully shy away from promoting the St Albans Partnership to the wider public. I see no benefit in getting photos in the local press at this stage. I strongly feel that we must first get the partnership in order and see results from it. However excited I may be to even get to this stage, the public rightly won't thank anyone if it goes nowhere. So until successes that residents can see and feel are made, I would rather we plug away in the background to make it work. Sharing as much as we can with other councils and health organisations, so that mistakes we may make aren't duplicated and successes can be replicated and refined far and wide.

Will the St Albans Health and Wellbeing Partnership live up to our ambition of creating a permanent difference? I hope so. For my part it has been a hugely rewarding experience, humbling and educational. The benefit of even small changes are already proving powerful, whether it is communicating across tiers of government and working *with* those who are experts in their field, to nurturing compassion by giving an equal voice to patient and volunteer groups, or the collaborations that are building trust and a greater understanding.

Ultimately, I hope in the coming years that the relationships forged will last beyond the partnership itself and the outcomes will ultimately be visible by the public. Not because of press releases or radio interviews, but in order to bring about a lasting change in their own health and wellbeing and of those that they love.

## 4 *The grass-roots politics of public health*

### Clr Keith Wakefield

**Many of us in local government are becoming ardent advocates of making sure decisions about localities, villages, towns, cities and regions are taken as closely as possible to the people those decisions affect. It's a belief that led me into local politics and one that keeps me here. And it will be key to enabling successful improvements to the public's health, tackling inequalities and empowering local people.**

We all know that there are overwhelming economic and demographic arguments compelling us all to do things differently. Today, the provision of services for communities is travelling along a new route by drawing together two mighty public service cultures – the NHS and local government. Although we rightly opposed the NHS White paper I am relieved that we managed to help change the final Bill through a lead role in the Future Forum. One of the least controversial aspects of the new legislation places the role of championing the public's health within the realm of our local authorities.

Public health began with nineteenth-century local government measures to combat overcrowding, poor housing, bad water and disease. These are examples of what we now call the wider determinants of health and councillors will recognise their major influence on these and many related areas. Including fair employment, housing, educational and skills levels, transport and access to leisure, sports and cultural services and giving children the best start in life. In transferring the responsibility for improving public health to local authorities, this important field of sustaining communities joins those which together provide the foundations of healthy and thriving communities - and which are already in the hands of local government.

Well almost. A good stock of housing underpins the health and wellbeing of every population. After decades of having our ability to provide decent homes undermined, local councils are at last regaining the powers to provide social housing and are increasingly doing so in more progressive ways that reflect more closely the health, age, ability and family-related diversities of

our communities. Education too, is long established as the local authority's responsibility to empower its citizens with the skills to create the economic wellbeing that supports healthy communities, families and individuals. Of course, economic development and regeneration in the widest sense creates jobs that feed families and helps nurture the kind of environment in which they might grow healthy. The links between a healthy economy and healthy people cannot be over-emphasised.

Here in Leeds, we long ago realised the importance of joining up local government services with partners such as health and have been working as 'one council' to achieve this. We strive to work across traditional boundaries and silos, both within and outside of the organisation. The arrival of colleagues from public health generates further opportunities for closer integration that we will seize upon in the coming months.

This is the opportunity, and the responsibility that lies with local elected members in leading the communities that elect them, and to safeguard and promote a civic life that is healthy in every sense. An important role of elected members is to ensure equality of opportunity and access to services across the diverse communities within our towns and cities. Public health statistics have long highlighted inequalities in wellbeing. Pockets of early mortality, low birth-weight, pulmonary conditions, cancers and nutrition-related illnesses rub shoulders with areas of affluence, where people live longer, stay healthier and have economic access to health and fitness.

In this new age of austerity, it is our responsibility to ensure the gap between prosperous and poor (and healthy and unhealthy) is not widened as we dip in and out of recession. We must also ensure that the new initiatives that we rightly need to embrace do not in themselves lead to further, new, inequalities: such as those related to access to information and technology. We all know that reducing differences in inequalities between communities will be a difficult task and one that will not be resolved overnight. But, it is the right thing to do, and we are making it a priority across all the health improvements that we want to achieve for the people of Leeds.

This brings me back to the importance (and power) of localism and our responsibility in making sure hard-to-reach areas and communities are

prioritised in our efforts to improve the overall health of our cities and towns. The importance of grass-roots politics has never been greater, in requiring elected members in their wards and constituencies to identify and champion the needs of groups disadvantaged by ethnicity, economy, age, ability, gender or sexual orientation. The councillor community itself is becoming more and more diverse and better able to reflect communities within communities, a development that has not come about by accident but is a deliberate attempt to be ever more inclusive.

Increasingly, councils are devolving their own decision making to localities and neighbourhoods; recognising that each is unique, with individual difficulties to overcome, and for which distinct – and different – solutions are required. This is a new kind of empowerment that is moving on from self-help in local communities, to embrace instead all sections of the community and society. Taking responsibility for our social, economic and physical health and wellbeing.

There are many names for it: social responsibility, civic duty and what more recently we are calling ‘civic enterprise’. It was my privilege over the past few years to chair the UK’s first Commission on the Future of Local Government. The Commission’s foremost proposition was that of ‘civic enterprise’ and the promotion of those civic entrepreneurs who exist in businesses, communities, councils and charities and who, if harnessed and empowered, can change our cities and towns for the better.

Local authorities are increasingly taking on the role of ‘place shaper’ and acting as catalysts for entrepreneurs within communities. In Leeds, in partnership with the Leeds Community Foundation, we fund an organisation called ‘Ideas that Change Lives’. Itself a social enterprise, it offers start-up funding for community interest companies, with successes ranging from a cookery school to promote healthy eating among disadvantaged people, to a ‘Keeping House’ service for older people living at home.

To achieve all of this, the Commission proposed that we need a new social contract that changes the nature of the relationship between citizen and government – national as well as local. Our new social contract places responsibilities on individuals and communities as well as on statutory and commercial organisations. We think that services should place an emphasis

on restorative practice, working with people instead of doing things to or for them. Our new social contract places responsibilities on individuals and communities as well as on statutory organisations.

A prime example of this is the well-rehearsed debate over who pays for the care and support needed by our increasingly long-lived population. This very longevity brings with it the twin requirements of working longer to pay for support in older age, and the need for more intensive packages of support as more people live for longer, but become more frail. We await the government's announcement on its vision for this in the future, but in the meantime our citizens need support and leadership in finding local solutions to ensuring adequate resourcing of care.

There are many ways that as elected representatives we can provide this leadership to improve the health of the people in our communities. The following examples are just a small selection of these:

- Developing relationships with health partners - especially our local GPs and clinical commissioning groups. We have more in common than we might think. When was the last time we met our local GP?
- Representing the views of our constituencies in health assessment and planning decisions. Make sure we know that these views form part of the JSNA.
- Using our local knowledge and constituency links to highlight health inequalities and promote health and wellbeing. What's right on a city wide-level might not be right for the people in our local ward.
- Ensuring that the decisions made by our authorities take into consideration the potential to improve the public's health, including the council's own workforce.
- Using our central influencing status with a range of partners to improve local health and wellbeing, especially working with businesses.
- Developing the role of health scrutiny to embrace the new public health responsibilities, and in particular making sure that we and our partners take account of our Joint Health and Wellbeing Strategies.

- Ensuring that our citizens and patients have a voice - and that this has made a difference to commissioning decisions, for example through Healthwatch.

The future of public health and wellbeing lies firmly in the hands of local leadership; be these political, social, commercial or entrepreneurial leaders – or a combination of these. One thing is certain – empowerment will be the name of the game if we are to succeed in creating a strengthened and more inclusive democracy for healthy, equitable and productive communities.



## 5 *From curing disease to promoting health*

### Sir Steve Bullock

Ten years after the creation of the National Health Service its founder Aneurin Bevan spoke in a debate in the House of Commons. The tone of that speech reflects much of the rhetoric around the NHS. He said, *“not only does the Service rescue people from a kind of twilight life, but their rehabilitation is of an enormous economic advantage. People are able to go about their normal vocations and to lead happy and contented lives, rescued from what was a near death.”*

Despite its name this was a service that was about making people well again, not a service that was about stopping them becoming ill in the first place. Illness was a fact of life and the NHS was created to help people overcome that. Prevention of illness was a matter of concern but primarily in the context of legislating to create a healthier environment. Thus the great London Smog of 1952 killed thousands and led directly to the Clean Air Act of 1956 – perhaps the single most effective public health intervention the country has ever known.

And as the years passed the NHS became better and better at keeping us alive. Medical interventions that were unthinkable to its founders became everyday occurrences. In a crisis the NHS was there, but the resources allocated to stop us becoming ill in the first place remained tiny compared to the ever rising cost of looking after people in hospital and providing the drugs and treatments that could help them become healthy again.

There is a tendency for human beings to live in the present, to give little thought to the future implications of our actions. After all we have only been organizing ourselves in ways which can fundamentally change the future for around 6000 years. The idea that we need to act in ways that will make a difference to us decades hence requires us to place reason above biological instincts. So it is hardly surprising that we behave in contradictory ways.

Of course some of things that we do to ourselves simply beggar belief. Drying the leaves of a plant and setting fire to them so you can inhale the smoke is a very odd thing to do even if you know nothing of carcinogens, and I say that as someone who smoked from the age of 15. But as the evidence became clearer and clearer about the effects of smoking we did begin to do something about it. It took decades to reach the point where today to be a smoker is to risk becoming a social pariah; across the world, millions of premature deaths are being avoided as a result. That battle is not yet completely won but it has some valuable lessons for us. Politicians had to make decisions that were far from easy to get even this far. A whole industry was prepared to fight them, and the doctors and researchers who provided the proof, every step of the way. Yet in the end, millions of people decided or were persuaded to stop or never to start smoking.

When I was 15, smoking was normal, it was celebrated on film and heavily advertised. Today it is frowned upon and rarely featured in the media. Can we replicate this change in other areas? It is this challenge that local councils must address as they take on a renewed role in relation to public health. The stakes are far higher than is often recognized. Unless there is a dramatic change in how we use the limited resources we have, the NHS and many other public services will face irreconcilable pressures on their shrinking budgets. Our population is growing and we are living longer. Demand for Adult Social Care is rising year on year.

After the economic crash of 2009, it took time for its significance towards public services to be understood. At the 2010 election, politicians dared not tell the electorate the truth – we could no longer afford to go on financing the NHS as we had been doing. Instead they talked of protecting its funding but failed to explain that ever improving medical knowledge means that its costs rise by 4% in real terms every year. In fact the old model of the NHS was coming apart at the seams. What we needed was a service which focused on stopping people needing to go to hospital in the first place. Yet the public debate continues to be about threats to hospitals, not about how best to improve the health of our population.

Politicians need to actively engage with this reality and explain that this is also something we can change. Let us take alcohol (another of my pleasures

but unlike smoking one that I have not forsaken!) as an example. If the consumption of alcohol was reduced it would, of course, bring benefits to the health of individuals but it would also reduce costs for the NHS and a range of other public services, such as the police and local authority cleansing departments. In many ways this is a harder ask than smoking – alcohol in moderation is a pleasure and causes little harm. It is excessive consumption that causes the problems and we need to be honest with our residents about the damage it does. They may well be aware of the effects on individuals but much less likely to appreciate the direct connection between the cuts that are proposed to arts and recreation services and the cost of dealing with the effects of excess consumption of alcohol – in short we can no longer afford to pay for both.

Many of the so called ‘life-style’ health changes we might promote do not have immediate impacts on us individually. We might feel a little better if we shed a few pounds but it is hard for us to imagine the impact years later – if we drank less and ate better would we reduce the chances of needing costly care in our later years? Of course we would but that isn’t usually how we think.

However those of us who run public services do have to think like that. Now we need to help our fellow citizens to do the same. We won’t succeed if we are sanctimonious and try to create a local “nanny state”. We need to engage firstly with those groups and individuals who understand the challenge. Together we need to find ways to create a different kind of dialogue – one that offers support and incentives to individuals but also describes the wider benefits that will come with improved public health.

The change we seek will not come through top down initiatives; it will come through the actions of our fellow citizens who recognize the challenges and who are able to promote healthier living in ways which also make short term impacts. Let us take diet: projects which teach us how to prepare good food using locally available ingredients offer hard up families the chance to have better quality food, rather than expensive, over-salted fast food. Crucially there are immediate benefits to the household budget as well as longer term health benefits, not to mention some environmental pluses too.

Councillors in their different roles have a vital part to play. On the executive side, they must advocate for health strategies that place prevention of illness at the heart of the work they and their partners do. This must be done in the context of financial restraint and better health outcomes. Local councillors can identify, support and advocate for those projects which are making a difference locally.

The projects already exist, or at least the individuals with the vision and the skills needed do. But too often they struggle for lack of resources – even quite small amounts make a difference and we must ensure that we properly understand the potential benefits, including relieving public services of future costs so that we make rational choices. Above all we need to place good health at the heart of what our public services and organisations do – it cannot be an add-on or after thought. In today's financial climate, helping people to stay healthy is core business.

## 6 *Making public health a 'doorstep issue'*

### CLr Ernie White

**One of the few things in the Health and Social Care Act that did not cause controversy was the return of the public health service to local government and the creation of Health and Wellbeing Boards. In Leicestershire we had requested early implementer status, so we watched the parliamentary battle with interest. We were anxious to get on with it!**

History tells us that local government has a proud record in improving public health, from providing sewers and clean water to building and running hospitals across the country. But that was a long time ago and the determinants of health are very different in the 21<sup>st</sup> century. Now that the sector is once again responsible for this most basic of public services we need to decide what we are going to do with it and, more to the point, whether we can improve on what the NHS did.

I became cabinet lead for health in Leicestershire way back in early 2011. It was a role I really wanted, as I have some experience of the health sector and believed that bringing public health back into local government presented the sector with a wonderful opportunity to do things better.

In the past, I have chaired a Primary Care Group, and then a Primary Care Trust so I had a taste of watching the NHS do its best to both treat ill people and prevent them getting ill in the first place. It seemed to me to be an unfair struggle! It's a few years now since I chaired a PCT but the memory remains of a service in desperate need of system change, a need to sharpen up its act, to raise its game. My impression was that there was enough resources in the system but that a lot of it was being spent in the wrong way.

Top down targets and a star rating system that named and shamed local managers for 'failure' mitigated against informed risk taking and stifled innovation, limiting the opportunity to try new ways of doing things.

There always appeared to be layer after layer of both management and governance structures. The service seemed to be in constant fear of structural change and there were so many targets and performance measures with armies of managers paid to tick the boxes. Sometimes I got the impression it was more important to tick a box than to make sure a patient got the correct treatment in a timely manner! Although the top down target stuff has gone, the challenge remains. How do we shift resources from treatment to prevention whilst meeting the need to treat the people who are ill now?

Today's local government uses the best of modern management techniques, and across many of our services we are now delivering a better service to residents on much reduced budgets. The NHS could, indeed must, do the same. Any change in the NHS has been keenly fought over. The service is special and precious, and any politician must be wary of public opinion and of giving the impression that the service is not valued. But unless the service changes it cannot endure. There will simply not be enough money to treat all those who need it never mind the overriding need to shift resources from treatment to prevention.

So what difference will giving councillors and councils more responsibility make? For many years the NHS has operated with a democratic deficit, micro-managed from Whitehall, with appointed non-executive directors on boards in an attempt to demonstrate public accountability, forgetting the truth about appointed representatives, which is that they are accountable to those who appointed them, not the public!

From now on the NHS and public health in particular will need to explain itself better to the public. Involving elected public representatives in this will give legitimacy and validation to challenging decisions. Councillors care about the people they represent, and not just for the obvious reason. Yes, they need their votes, but, more importantly, the vast majority of councillors see themselves as public servants engaged in public duty, and will support what they see as best for local people.

So if the NHS wants to change things for the good of the local population why wouldn't local councillors be supportive and helpful? This support will be vital when beds are taken out and maybe hospitals closed, not for cost

cutting reasons, but because we no longer need so many as the results of the vital shift to community provisions and prevention emerge. Modern surgical techniques and therapies require shorter stays in hospital which means that the high fixed cost of supporting permanent beds and buildings can be reduced without reducing the quality of care for patients.

The whole landscape of the NHS has been dramatically changed by this Act of Parliament, and this new landscape of provision must be scrutinised and monitored by all councillors. So, even though health and wellbeing boards will sit within unitary and upper tier authorities, in two-tier areas districts and their representatives must be engaged and involved if the new system is to deliver its potential.

In Leicestershire I believe I am fortunate. As well as being a member of the county council cabinet, the lead member for health and the chair of the Health and Wellbeing Board, I am also lead one of the district councils. Leicestershire districts are represented on the board with two members, who benefit from the support of a district chief executive. Each district has its own health member champion, usually the cabinet portfolio holder, and in each district there is a local health forum promoting programmes supporting public health in each locality.

The district tier, up to now virtually ignored by the NHS and left out on the periphery of the effort to improve public health, is central to improving public health. Through the engagement of districts, health and wellbeing boards and CCGs can harness resources and facilities such as leisure centres, parks and open spaces, housing support, economic development, environmental health, community development and strategic planning. These are the vital services, supported by professional officers and committed local members, that can really impact on health and wellbeing outcomes in a locality.

In the changing world of local government other opportunities arise. When county wide local education authorities lose 'control' as schools go for self-governing academy status, why not link up with district authorities to enable community-wide sport and activity programmes? In my view there is an untapped opportunity for district councils to forge partnerships with

health at local practice and health centre level, promoting exercise and softer therapies, such as community gardens and other group activity for patients recovering from serious illness, and in particular for those challenged by mental health problems.

What local government has been offered is an opportunity, a chance to really make a difference to the health of our local people. An opportunity to 'localise' public health, engage local councillors in tackling the challenges revealed in the local health profiles, bring new thinking to tackling health inequalities and to design public health strategies into every service delivered by local government; to make public health a 'doorstep issue' if you like. Can local government do it? You bet we can, you just watch!



## *About the contributors*

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**The return of public health to local government is probably the biggest single transfer of new responsibilities for decades. Many in the sector are justifiably excited by the change. Public health is much more than a question of providing specialist services: the task is to bring an active concern for health outcomes into the mainstream, across housing, planning, licensing and social care. Ultimately, it is about mobilising the whole council and many of its partners to create the conditions for the public to adopt healthier lifestyles.**

We have gathered together perspectives from five leading politicians across the country to understand how they plan to approach the new role. This is localism in action, so unsurprisingly the essays offer a wide variety of perspectives: from the district council which has no formal power, but has set up its own health and wellbeing partnership, to the city leaders looking to encourage the consumption of nutritious, locally-grown food.