Community wellbeing

The health of the public

Local Government Group discussion paper

Contents

This document has been produced by the Local Government Association (LGA) in response to the Government's NHS White Paper 'Equity and Excellence: Liberating the NHS' (published November 2010).

Foreword

The forthcoming Public Health White Paper can be viewed from two different perspectives: it can be seen as an opportunity to secure increased resources and consolidate the public health workforce; or it can be viewed as a unique opportunity to put health improvement at the heart of public services, and to drive everything we do. While we acknowledge the valuable contribution of public health professionals, we want to ensure that local government plays a leading role in making health improvement a part of everyone's job.
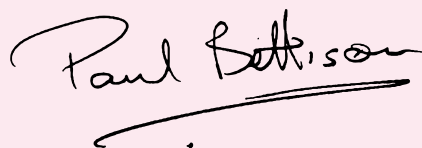
This executive summary outlines the Local Government Group's (LG Group) key messages on how we can turn this aspiration into a reality. It will involve developing new roles and relationships: with our communities to have a mature discussion with them about local health improvement priorities; with GP commissioning consortia on how we can transfer resources from treating sickness towards promoting health and wellbeing; and at national level, with government, on the need for them to empower local government and their partners to develop their own strategies for delivering better health.

We have already given our support to the government's proposals to transfer public health to local authorities, outlined in 'Equity and excellence: liberating the NHS'. We have made substantial comments on their proposals and we look forward to discussing with them how we can build on the extensive good practice that already exists to 'mainstream' health improvement in all local plans, services and partnerships.

We want your views on our key messages. Do they strike a chord with you and your partners locally? Or do you have other concerns? We are keen to ensure that our response to the Public Health White Paper reflects the interests and concerns of local government and we will be sharing our emerging messages with you in the near future. We want you to help us shape the new agenda for public health.

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Introduction

1. Public health has always been at the very heart of local government. The Local Government Group welcomes the proposal to transfer responsibility and funding for local health improvement to local authorities, giving them a much more influential role in promoting the health of the public. This will enable councils to provide democratic leadership and local accountability to deliver improved health outcomes and challenge health inequalities. Action is still needed across partners and partnerships. The public, voluntary and private sectors must work together on this.

2. Local government has a leading role in addressing health improvement challenges, because so much of what it does has a crucial relationship to all the factors which enable or prevent people taking responsibility for, and making informed choices about their health.

3. The issues that impact on the health of individuals, families and communities are wide-ranging, complex and interrelated. To affect change we must work harder to address the wider structural, financial, social and environmental influences on health. What Sir Michael Marmot calls in his report, "the causes of the causes". (Marmot et al, 2010 p60)

4. This paper provides a snapshot of how councils already work to integrate health improvement into mainstream service delivery – from transport, planning and leisure, to housing, environmental health, education and social care. We know that, given the power and freedom to act locally, we have an even greater contribution to make. Councils are ready to lead and empower communities, neighbourhoods, families and individuals to deliver a 21st century revolution in public health with an emphasis on the **health of the public** rather than public health activities. This will put the health and wellbeing at the heart of all our plans and services. As this paper illustrates, an ambitious and modern approach requires freedom, flexibility and support.

The LG Group's five tests

5. The LG Group's response to the Government's proposals for health reform has been underpinned by five key tests. These are:

- Do the proposals build on existing good experience and good practice?

- Do they support a 'local budgeting' approach?

- Do they promote a person-centred approach?

- Do they ensure accountability and governance to local communities?

- Do they ensure that public resources are directed to the areas of greatest need?

The application of these tests to the Government's proposals has been discussed in detail in our response to the recent NHS White Paper and is not reproduced here; however, the comments below on the changes required if local government is to deliver on public health and the risks threatening their success are based on the application of these five tests. In particular we see flexible local budgeting that enables all local partners to work together to deliver better health as essential to the realisation of the benefits of the Government's public health proposals.

Local government and public health

Local government is built upon and has always had a strong role in public health. The public health challenges we face have changed since the nineteenth century but local government's role remains pivotal. Over recent years public health policy and practice have become increasingly medicalised, narrowly targeted and fragmented. Local government is today reasserting its role in improving the health of the public. In the light of new challenges and with the growing recognition of the importance of addressing the social determinants of health, government at all levels has recognised that improving the health and wellbeing of the public is beyond the remit of the NHS alone and firmly within the territory of local government.

Inequalities in health and healthy life expectancy that can be addressed by policy are unfair and unjust. While health has improved for everyone, including disadvantaged groups, the overall gap in life expectancy in England today is no narrower now than it was 25 years ago. Sir Michael Marmot's Commission estimated

that inequality of illness costs the economy between £56 and £60.5 billion per year. The economic benefits of moving the pensionable age to 68 will largely be counterbalanced by his prediction that at least 75 per cent of 68 year olds will have long-term conditions that will limit their ability to remain economically active. Recent work by Local Government Improvement and Development (LG Improvement and Development) indicates that councils could make significant savings by investing in the public health activities that are already part of their mainstream service provision.

The Marmot Review 'Fair Society, Healthy Lives' identified six policy areas central to reducing health inequalities:

- give every child the best start in life
- enable all children young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention.

The Marmot objectives are about fundamental aspects of life. Like many of the current challenges that face us in local government, health inequalities operate across complex and interrelated social, economic, behavioural and environmental systems. These do not seem to respond to narrow, targeted, medical, behavioural or lifestyle interventions and the importance of finding new, more effective ways of meeting the public health challenge must not be underestimated.

The simple creation of a public health function or service will not be enough on its own. Health inequalities can only be addressed through multi-faceted approaches. Their complexity requires cross-organisational partnerships that embed public health objectives in a wide variety of work-streams. Effective partnerships require leadership that is local and accountable. Only councils can provide this building on existing good practice on tackling inequalities through action on the social determinants of health.

Local Government is committed to local budgeting. Experience of bringing together all the resources in an area has shown the potential productivity and efficiency gains. But this is not all, added to these important gains is the potential to re think the relationship between the public sector and the citizens it serves, to place communities at the heart of decision making, in the driving seat for achieving better health outcomes for local people. The Local Government Group believes this approach provides the best basis for delivering the health of the public.

Councils' contribution

Councils are already demonstrating their commitment to leading on public health. The case studies throughout this publication demonstrate a consistent message: council-led partnerships can bring a variety of services to bear on public health issues. These not only deliver tangible health and wellbeing benefits to the population and produce health care savings through preventative interventions; they also achieve efficiency savings by joining up services utilising both business and third sector resources.

In every local authority area there are numerous work programmes that involve health service, local authority and voluntary sector staff working together, often out of the same offices. Many councils are embedding health and community impact assessments into every day planning processes and working to establish GP consortia and more effective commissioning arrangements.

Previous approaches to challenging health inequalities and improving the health of the public have failed because they have been too process driven and centralised. They have lacked the necessary synergy between public health and mainstream services. Even in the NHS, public health has often had only a peripheral role in mainstream health service provision. In addition, national top-down approaches have failed to reverse rising trends in obesity, sexually transmitted infection rates, excessive alcohol consumption and drug problems. Often these approaches have focused on diseases and conditions rather than the whole person, family or community.

An effective public health system will involve a diverse landscape of local solutions in which councils have the power to lead, the freedom to decide the key issues for their area and how best to tackle them. Local control is not only effective, it is right. Local communities must be free to identify their own public health priorities and given the power to address them through a democratic and accountable structure. If the Government's public health reforms are to succeed, we need more than just councils providing public health services. Councils need the flexibility to expand responsibility for health outcomes beyond the public health profession and embed it in **all** services provided for and with communities.

What would an effective public health system look like?

Key messages from the Local Government Group.

Making health everyone's business
We need to make health everybody's business. The government's proposals in the White Paper 'Equity and excellence: liberating the NHS' present clear recommendations for major restructuring, not just health services but also councils' responsibilities in relation to health improvement and the co-ordination of health and social care. The White Paper focuses on removing unnecessary bureaucracy and devolving power to the local level. It also proposes the transfer of health improvement to local authorities. This requires a complete change in our current approaches to Public Health. Almost every aspect of council activity has an influence on the health and wellbeing of the population. The breadth of local authority influence on health and wellbeing is illustrated in figure 1. If responsibility for public health is to be devolved to councils and to local communities then they must be given the power to lead and the freedom to decide what their health priorities are.

The time has now come to let local government hold the purse strings of all public sector spending on improving the health of the public and allow us to move towards a broader vision of public health with communities at its heart. This does not just necessitate devolving spending

decisions to local government, but allowing councils the flexibility to devolve these decisions to communities, neighbourhoods and individuals. Subsidiarity will be a key principle.

Local government will need the continuing support of public health specialists to ensure that we are maximising our opportunities to improve health and challenge inequalities. However the White Paper offers us an opportunity to move to a local model that looks more broadly at the 'health of the public' rather than 'public health'. This will involve the leadership role of councillors on Health and Wellbeing Boards (HWBs); engaging with and developing communities to achieve their aspirations and address their needs for health and wellbeing; all public sector staff understanding how they can contribute to health improvement through their jobs; and every individual being clear about how they can take responsibility for their own health.

The Joint Strategic Needs Assessment (JSNA) will continue to have a central role in setting the local health agenda and must be the key process for ensuring that all partners and all contributors have a common understanding of the local issues and evidence from which to work. It must be costed, relevant, influential and include an assessment of the assets and strengths of local communities, agencies and associations and their potential to

The social determinants of health and wellbeing

How local government can make a difference

Global Ecosystem
Natural Environment
Built Environment
Activities
Local Economy
Community
Lifestyle
People

age, sex
hereditary factors

contribute to improved health outcomes. A growing body of evidence shows that when professionals begin with a focus on what communities have (their assets) as opposed to what they don't have (their needs) a community's efficacy in addressing its own needs increases, as does its capacity to lever in external assistance.

Efficiency and productivity

We strongly support the renewed focus of the NHS White Paper on public health and health improvement. This is not an optional add-on but an absolute necessity if we are to reduce the projected impact and future costs of poor health and an increasing demand for social care. In particular we need to urgently address widening inequalities in health.

Local government needs to demonstrate how current good practice in health improvement can save money and improve health outcomes. Investment in health improvement activities and early intervention can lead to more effective services and better health and wellbeing outcomes for less money. We will ensure that the need for efficiency drives effective and sustainable health improvement.

Community budgeting, an integrated approach with all agencies taking ownership and responsibility for health improvement, provides an incentive where work by one agency delivers savings to another. In practice, attempts to divide spending on public health from other spending will lead to artificial partitioning of activity and hamper efforts to bring the range of council and partner activities to bear on the more intractable and complex health challenges. As the case studies show, councils need to be free to mobilise a wide range of activity. Effective communication and mature relationships will ensure best practice can be shared and all councils have the chance to learn from each other's experiences.

Focusing on health outcomes
Public health work must be outcome focused and accountable, not process driven. We welcome the shift from centrally imposed process and output targets towards locally determined solutions to improve outcomes for local people. How we achieve these outcomes will be shaped at a local level by citizens, service users, elected representatives, commissioners and providers. We support a single outcomes framework for the NHS, social care and public health to inform and drive local action and services.

It has proved very difficult to compile an evidence base on what works in terms of reducing health inequalities and there is very little robust academic research in this area. Flexible approaches to evaluation must be developed where the long-term nature of a project's outcomes or a lack of suitable baseline data would pose challenges to traditional forms of assessment. We must continue to work with our public health colleagues and especially the National Institute for Health and Clinical Excellence (NICE) to improve the evidence base.

Ultimately, all partners should be working towards agreeing a simple and clear set of locally relevant outcomes that are more responsive to local circumstances. These should measure not only health improvements but also wider outcomes such as improved wellbeing, resilience, independence, more choice, greater control and reduced inequalities in health.

Local budgets for health improvement
We are pleased the Government recognises that councils will require additional resources to undertake their public health role. However, the imposition of a ring-fence is at odds with the place-based approach advocated by the Local Government Group. The recognition that some areas face much bigger challenges than others in tackling health inequalities by allocating a 'health premium' is also welcome. This will enable these places to continue some of the innovative approaches that they have developed.

Ring-fencing of public health funding risks encouraging silo working by dividing public health activity from non-public health activity. In reality virtually everything councils do has an impact on the health of the public. A local budgeting approach to the health of the public can act as a catalyst to innovative, joined-up and whole-systems approaches to improving health.

Personalising health improvement

Local government has been implementing a personalised approach to social care and support and has made impressive progress in some areas on empowering individuals to choose the support that best meets their aspirations and needs. We are keen to work with our colleagues in public health and the NHS to share the learning and embed personalisation in our approach to improving the health of the public.

We need to support individuals, families and communities to make choices that improve their health. We also need to acknowledge that some are better able to make healthy choices than others. We must ensure that personalisation addresses health inequalities and does not widen existing inequalities.

Putting localism into action

National targets have failed to make a big enough impact on health improvement and tackling health inequalities and have been costly and time-consuming. We strongly support proposals to transfer responsibility for improving the public's health to local areas. Public health and population-based work must be tailored to the strengths and needs of individuals. Giving the community a voice and ensuring everyone understands their role will provide the sense of participation and personalisation that is necessary if some individuals are to feel empowered and supported to control their own health; to take more responsibility for their own lifestyles; as well as become involved in local activities and outcomes.

The central role of councils in ensuring this is paramount. It is consistent with existing developments in many areas and the historic role of local government in public health and healthy communities. Real localism means that each area will determine their priorities for health improvement based on their

particular assets, needs and circumstances. There is a danger that this could be perceived as a 'post code lottery' when, in fact, it is the expression of significant local differences. The council as the leader of local partnerships and accountable to the local electorate is best placed to make a locally relevant, informed and accountable decision. Of course this will lead to variations in spending on different priorities in different places, but we should not always assume this is a bad thing. In improving the health of the public one size definitely doesn't fit all. A distinction needs to be drawn between the universal standards expected of medical treatment in the NHS and the diversity of local approaches that are required in addressing public health challenges. It will be important for central government to trust local government and their partners to make the right decisions for and with their communities and resist the temptation to impose a top-down approach.

Local accountability for health improvement

Health and Wellbeing Boards (HWBs) will need to engage with and develop the current arrangements for public and patient involvement, advice, liaison and advocacy as well as with their local communities and stakeholders. However, this alone is not sufficient to ensure local accountability. Councils will need to retain their health overview and scrutiny functions to hold the executive to account for decisions affecting the health and wellbeing of local people and communities.

We look forward to discussing with government how Health Watch can help to hold HWBs, commissioners and providers to account for improving the health of the community.

Barriers that are preventing this change and risks to achieving it

The government's proposals for public health provide an opportunity to achieve the effective local system outlined above, but there are elements of the proposals that will need careful thought if the risk of recreating previous less effective structures is to be avoided.

Public health issues vary between areas. Centralised, top-down prescription can hamper local responses and solutions. It will be important to avoid recreating national indicators and the bureaucratic structure of centralised reporting associated with them if real local change is to be effected.

National politicians and government departments must resist the temptation to respond to concerns about the 'postcode lottery'. If localism is to have any meaning and authority then local areas must have the freedom to identify their health improvement needs and assets, agree their priorities and commission appropriate services to improve outcomes. Local areas' health needs vary and HWBs will be best placed to make a locally relevant, informed and accountable decision.

Activity must be outcome focused and evidence informed. Too narrow an approach to cost benefit analysis carries the risk that important work is ignored because the outcomes are too long-term, the impact of a specific intervention is too hard to isolate or there is insufficient baseline data. A flexible approach to evaluation and relevant data gathering machinery - linked to local needs - are required.

A new organisational structure for public health is clearly necessary. However there is always a danger that a prolonged period of reorganisation leads to a loss of expertise, organisational memory and discontinuity. It is important to avoid conflicting or contradictory messages from other legislation and White Papers. The LG Group is committed to support the sector through the transition process.

Under the proposed changes, the familiar dilemmas and challenges of partnership working are likely to resurface, regardless of the structures put in place. In keeping with the government's emphasis on localism, the emphasis needs to be on identifying what is wanted and works in a particular local area rather than seeking to impose a standard set of structural requirements on all areas. Too much emphasis on structure is likely to result in an approach to partnership working that suffers from being over-engineered. Structures do not deliver improved outcomes – people do. More critical is ensuring that the right people are round the table and that the table is 'set' at the right level. If every decision is made at county level, districts will disengage, but if everything is devolved to the front-line, some strategic initiatives may become fragmented and ineffective. Flexibility is the key to allowing councils to get this right.

It is important to avoid creating a new silo in local government called 'public health'. Instead, work to improve the health of the public must be embedded in the everyday work of councils and their partners.

Traditionally the GP's role has focused largely on the health of individual patients and far less on the issues that determine the health of whole populations and communities. With the Government's proposed changes GP consortia will become an important player in the commissioning local public health services as well as commissioners of services for their patients. Closer links with local authorities will be required.

Directors of public health are set to have a vital role in the new structure but the existing joint posts are still relatively new. In particular, we do not know which models or skill sets are most effective for working in a more distributed system and outside the linear performance management structures and relationships in the NHS. Local Government Improvement and Development's work in describing the essential skills required by Joint DsPH to work effectively with local authorities has identified some of the challenges of working in a system driven by local democratic accountability and locally set priorities. We await the government's proposals about how joint accountability of DsPH will work in practice.

Conclusions

If the government's proposals are to be effective they must produce a public health approach which is:

- flexible

- led by councils free to decide how to deliver and empowered to lead.

- fully inclusive of partners including GP commissioning bodies

- outcome focused and evidence informed

- embedded across a wide range of place-based activity.

Such a system will allow councils to resume and develop even further the public health leadership role they have effectively delivered in the past and to rise to the challenge of improving the health of the public in the face of the complexity and diversity facing us in the 21st Century. To this end we reiterate the following key points:

- We strongly support proposals to transfer responsibility for improving the health of the public to local authorities. This is consistent with developments in many other areas and the historic central role of local government in health improvement and public health.

- On ring-fence of resources for public health, we are pleased the Government recognises that councils will require additional resources to undertake the public health role. However, the imposition of a ring-fence is at odds with the place-based approach advocated by the LG Group.

- We urge the Government to clarify the level of resource to be allocated to local authorities to meet the proposed public health duties and to remove the ring-fence to enable councils to use the resources to greatest effect locally.

- On public health priorities and outcomes, we welcome discussions with Government on clarifying how local and national priorities will be balanced.

- We strongly welcome the proposal to transfer directors of public health into local councils. We welcome discussions at both national and local level on the future role of the DPH within the council, and the additional skills they will require to undertake their functions. The LG Group believes that it is for local authorities to determine what resources and workforce they require to fulfil their responsibilities to improve health and wellbeing. The LG Group would not support any centrally or regionally imposed transfer of public health staff from the NHS to local authorities.

- We strongly support the creation of Health and Wellbeing Boards to provide local leadership and a strategic framework for co-ordination of health improvement in local areas, based on local health needs and assets identified by the Joint Strategic Needs Assessment.

- The LG Group supports the proposal for HWBs to be a statutory requirement for all upper-tier local authorities. Though unitary or upper-tier authorities should be the basic building block for HWBs, they will need the flexibility to join together to work in sub-regional and supra-regional groupings; and break down into smaller areas – neighbourhoods, parishes and districts to more effectively engage with local communities. It will be necessary to consider how districts and district level services, such as environmental health, can be represented on Health and Wellbeing Boards.

- Though we believe that the composition of HWBs should be for local determination, the membership will need to include chief officers, senior lead members, GP commissioning leads and representatives of patient and user groups as a minimum. Furthermore, they must be able to take independent decisions rather than being required to report back to nominating bodies. This will ensure that HWBs are agents of change to improve the health of the public rather than talking shops.

- The LG Group supports the functions proposed for HWBs outlined in the White Paper. We also propose additional powers and responsibilities to sign off GP commissioning plans; for GP consortia to be required to contribute to the JSNA; for HWBs to be required to publish an annual joint commissioning plan; and for local HWBs to have equality in statute with the National Commissioning Board.

- The unanimous view from all of the local government stakeholders is that councils will need to retain their health overview and scrutiny functions to hold the executive to account for decisions affecting the health and wellbeing of local communities. The HWB, as proposed in the White Paper, is clearly an executive body with wide-ranging commissioning responsibilities and cannot, therefore, hold itself to account. The roles, powers, membership and accountabilities of HWBs and HOSCs will need to be clearly defined and communicated and distinct from each other.

Appendix 1 – local government's contribution

The issues that impact on the health of communities are wide-ranging and complex. Interventions focusing on individual lifestyle choices around physical activity, smoking and healthier eating have an important role to play. However, as this section and the selection of case studies highlights, the public health contribution of local government extends far beyond this.

Councils are already demonstrating their commitment to leading on public health; council-led partnerships can bring a variety of services to bear on public health issues. These not only deliver tangible health and wellbeing benefits to the population and produce health care savings through preventative interventions; they also achieve efficiency savings by joining up services utilising both business and third sector resources.

In every local authority area there are numerous work programmes that involve health service, local authority and voluntary sector staff working together, often out of the same offices. Many councils are embedding health and community impact assessments into every day planning processes and working to establish GP consortia and more effective commissioning arrangements.

Public health permeates every aspect of local government. While many in the local government sector recognise this, it sometimes takes an extraordinary event to demonstrate just how well local government can pull together with its local partners to protect and improve the health of the public. Such was the case in Cumbria with the councils response to the floods of November 2009.

Regulatory services work closely with local business and ensure that the environment in which we live, work and play enhances our health - creating healthy workplaces; reducing alcohol and tobacco-related harm; maintaining acceptable standards of private rented housing; improving air quality, food standards and safety; ensuring consumers are sold safe products; and working with retailers and caterers to promote healthy eating. Norfolk County Council is working in partnership with local producers to reduce the levels of salt in bread and sausages and rethink the role of local food businesses as custodians of health. The project has also identified savings for local producers and promoted local food by supporting producers to meet consumer demands.

Children's services - The Marmot Report emphasises that giving every child the best start in life is a key factor in ensuring future healthy outcomes. There is very good evidence that intensive programmes working with pre-school children and their families can have substantial long-term benefits on their outcomes. There is a robust association between educational achievement and a whole range of improved health outcomes.

The cost of multi-agency early childhood programmes is far outweighed by the future benefits of these. They include improved educational attainment, increased employment and earnings and lower levels of crime. These outcomes can also constitute important efficiency savings for local authorities and other parts of the public sector. Birmingham City Council is further developing its early intervention and prevention approach to outcomes for children, focusing on tackling the underlying causes of problems such as drug and alcohol misuse and poor mental health in later life. Building on high quality evidence has been the cornerstone of their approach.

Adult social care - Due to the increasing cost of providing care for older people the potential for efficiency savings as a result of early interventions is substantial. Considerable savings are likely to be produced, even in the short to medium term, by interventions that specifically improve older people's capacity to live independently or with low levels of community support. Delaying entry into residential care or a nursing home, even by a short time for a small proportion of the population, may result in substantial savings. Croydon's Partnership for Older People (POP) brings together a range of council and health services and the voluntary and community sector to provide targeted intervention and advice in the community to improve the health and wellbeing of older people, reduce health inequalities and realise savings by reducing hospital and residential care admissions.

The most important way in which local government **planning and environmental services** can promote healthy communities is by creating an environment which encourages active transport choices. There is good evidence that urban design and land use regulations, policies and practices can be effective in increasing walking and cycling, particularly in mixed land use, high-density areas and improving pavement quality and connections. Redesigning places with people in mind, through better connected walking routes, car-free cycling routes, community green spaces, improved lighting and enhanced aesthetics are examples of positive initiatives that increase the number of physically active people. Improving air quality is a health and wellbeing priority identified within Sheffield's 2010 Joint Strategic Needs Assessment as a key action to reduce health inequalities.

Transport policy has the potential to improve health by improving road safety, reducing accidents, and mitigating the negative impacts of road traffic. Some successful strategies include school-based programmes to increase the use of cycle and motorcycle helmets; traffic calming schemes; speed limit zones; alcohol-use controls and legislation; and behaviour-change programmes to encourage people to shift their transport choices towards walking and cycling. Bristol City Council and NHS Bristol are jointly piloting two large 20 miles per hour (mph) limits in parts of the city with higher health needs. As well as fewer injuries and deaths, other potential benefits could include more physical activity, less traffic noise and better air quality. These can lead to reductions in obesity, diabetes, heart disease and mental health conditions.

Poor **housing** is associated with negative health impacts. Substandard housing is linked to a higher risk of chronic diseases such as asthma; mental health conditions and the spread of infectious diseases. Local authorities can help to promote health by ensuring that council-owned housing meets decent housing standards; through their regulatory role in relation to houses in multiple occupation; and by focusing on urban regeneration programmes which combine housing improvement with

other interventions designed to address unemployment and social exclusion. All have a role to play in reducing inequalities and building more cohesive communities. Affordable warmth programmes and housing adaptations can also have a substantial impact on health - especially for people who are older or disabled - by helping them to live independently.

Being in work has a strong beneficial impact on health across all social groups. Councils have a well-established role in providing **support to business** and encouraging new business start-ups in their locality. Local authorities are a valued source of advice and support on regulations for business. Evidence indicates that health and safety enforcement and advice as well as occupational health schemes are effective in reducing injuries and work-related ill-health, reducing sickness absence, compensation claims and improving employees' general health.

The individual impact of both **crime and the fear of crime** include both physical and mental health problems. Communities with high crime rates and levels of fear of crime have worse physical and mental health outcomes. The evidence indicates that a range of strategies including Crime and Disorder Reduction Partnerships, early childhood interventions, Neighbourhood Watch programmes and community-oriented policing both reduce crime and improve health and wellbeing.

Local authorities have an important role to play in **the prevention of harmful drinking and drug use**. This includes the enforcement of alcohol licensing legislation, educating the public and working with other agencies such as health and police services to minimise the harm caused by alcohol and drug use. It has been estimated that 31,000

deaths a year are attributable to alcohol consumption in the UK. Approximately half of all violent crime and a third of all domestic abuse is linked to alcohol misuse. Given the strong links between alcohol, drug use and violence and crime, there is good reason to think that successful interventions are likely to have important impact on these. Gateshead, Sunderland and South Tyneside Councils are working together to create long-term partnerships to improve social outcomes and make efficiency gains in relation to alcohol and drug misuse. The project is working towards a multi-disciplinary approach to families most at risk in 'hotspot' neighbourhoods, aligning work to change social attitudes and behaviour around alcohol misuse, and better collaboration across the three Crime and Disorder Reduction Partnerships.

Case studies

Brighter futures in Birmingham:
A 'public health approach' to improving outcomes for children

Birmingham City Council is further developing its early intervention and prevention approach to outcomes for children, focusing on tackling the underlying causes of problems such as drug and alcohol misuse and mental ill health later in life. Building on high quality evidence has been the cornerstone of their approach.

The challenge

On average, people in Birmingham have shorter life-spans and worse health than the rest of England. And the social gradient of health inequalities exists across different areas of the city and between different occupational and social groups. The need to reorient health spend from treatment to prevention was highlighted in a financial mapping exercise carried out by Birmingham City Council which showed 96 per cent is spent on treating illness and only 4 per cent on keeping people well.

Untreated, 40 per cent of children with early behavioural difficulties go on to develop conduct disorder and may go on to misuse drugs, become involved in criminal and violent behaviour and are unable to form attachments leading to mental health problems in adulthood. Birmingham found that around 20 per cent of children aged 7-18 in the area would be likely to develop conduct disorder.

Action

The Council's Brighter Futures programme, which began in 2008 and involves a wide range of partners, is piloting a number of evidence-based early intervention and prevention programmes against 6 outcomes: physical health, behaviour, emotional health, literacy and numeracy, social literacy and job skills.

A data collection and consultation exercise pointed to a need to give parents more support and this forms a large part of their approach. The aim is to empower parents to help themselves and their families through skills development and building confidence.

The pilot intervention programmes will be used to create change in the wider system and move even more from service-led thinking to planning and delivery based on outcomes.

Birmingham is also learning from evidence from USA and Australia and plans to develop their approach to include community-wide media and information to accompany interventions, which will seek to change social norms in parenting across the area.

Outcomes

Improved outcomes earlier in life lead to better life chances and reduce the demand for high cost services in later years. Birmingham has calculated that the cost of implementing the evidence based parenting programme will save £2 for every £1 spent for council children's services, with a potential 4:1 saving across all agencies over 15 years.

The outcomes of the programme will be seen in the long-term as children grow and prosper. Building on high quality evidence has been the cornerstone of Birmingham's approach. Epidemiological data has been collected from over 14,000 children and young people with standardised measurements and the surveys run on an annual basis. The council is also utilising a sophisticated multidimensional outcomes model that brings together epidemiology, data sets, local and national statistics, performance indicators, customer views and demography alongside cost/benefit analysis tools.

One of the barriers to taking a preventative approach identified by Birmingham is that measures take a number of years to generate overall savings. There is therefore a need to move public investment from a short timeframe to a longer period.

Croydon Partnership for Older People Service

Croydon's Partnership for Older People (POP) brings together a range of council and health services and the voluntary and community sector to provide targeted intervention and advice in the community to improve the health and wellbeing of older people, reduce health inequalities and realise savings by reducing hospital and residential care through prevention.

The challenge

Long-term care for older people is costly and accounts for a substantial proportion of councils' overall expenditure. Long-term care is estimated to cost £11 billion currently and is forecast to rise to £15 billion by 2040.

Evidence showed that there were health inequalities in Croydon. Those living in the south of Croydon could expect to live five to six years longer than people living in the north west of the borough and people from black and minority ethnic groups have a higher chance of having a stroke or developing diabetes than other groups. However, there was no geographically or ethnically targeted provision of relevant services the borough.

Action

The underlying aim of the programme was to create a sustainable shift in resource and culture away from a focus on institutional and hospital-based crisis care for older people, towards earlier and better targeted interventions within the local community. POP is a partnership between the council, voluntary and community sector (VCS) and the primary care trust.

The partnership is committed to providing a 'whole system', person-centred approach to the wellbeing of people over 55 years old that extends beyond health and social care services.

At the centre of POP is a mobile service which brings a variety of support, advice and information direct to older people and their carers in their own community. The purpose built bus provides a wide range of services including health check ups, medicine management, information on activities and events, falls prevention services, support for choosing a healthy lifestyle, supporting independence in old age, advice on home safety and security (involving crime prevention officers), advice on keeping warm in winter and reducing fuel costs (linking with Croydon Energy Network), advice on benefits for older people and their carers, housing advice, sheltered and extra-care accommodation (working with the Housing Department).

Outcomes
Efficiency was improved, duplication of activity reduced and joint resources used more effectively to support and care for older people.

Based on conservative assumptions of a reduction of 25 per cent in emergency hospital admissions or access to residential care relating to blood pressure and 5 per cent of service in relation to other referrals such as falls prevention, smoking cessation and dietary advice, the savings to the organisations in 2008/9 were calculated to be £2,523,288.

During 2008/9, POP came into contact with 16,100 older people and/ or their carers and relatives, nearly 65 per cent of whom were female. About 30 per cent service users are aged 85+, and 60 per cent aged 75+. The

POP welfare rights team assisted POP users to claim over £900,000 increased benefits in 2008/9.

Service users have highlighted benefits including greater independence and a higher quality of life arising from, for example, improved mobility, reduction in pain and anxiety, access to a wider range of services (especially in their own neighbourhood) and increased income from benefits (for some individuals doubling their weekly benefit income). Some have commented on the positive social function of going out to the bus and meeting people.

In ensuring the VCS has a major role in managing and delivering the service, POP has contributed to a healthier and more sustainable sector in Croydon and resulted in a more mixed local economy of service provision for older people. It has contributed to an increase in the number of volunteers across the borough and opportunities for a more active lifestyle and satisfying role for older volunteers.

Public health aspects of councils' response to the Cumbria floods of 2009

The challenge

Following unprecedented rainfall in November 2009 a total of 2,239 properties in Cumbria were flooded, around 1 in 5 were business premises. Allerdale and South Lakeland were the worst affected districts. Workington was cut in two by a series of bridges collapsing and a 16 mile detour was required to cross the town.

The health consequences included:

- the risk of disease from sewage or damage to food storage facilities
- lack of access to food, energy supplies and key services
- the implications of homelessness and anxiety
- the significant economic damage inflicted, in particular in Workington and Cockermouth.

For example, in north Workington it is estimated that around 7,000 people were unable to access their GP surgery. Socio economic analysis of the communities affected across Allerdale using ACORN datasets shows that older residents have been disproportionately affected.

Initial response

Cumbria Fire and Rescue Service received over 400 calls for service in one 24 hr period.

Allerdale Borough Council opened reception centres; housing teams assisted people made homeless; building control teams assessed structural safety of buildings and thousands of sandbags were distributed by the property team. Environmental health officers advised on food hygiene and infection control, including at reception centres, to prevent the start of mass infection/food poisoning. Cumbria County Council Highways Teams managed road closures and monitored flood impact. Traffic management plans were put in place. Adult social care staff helped ensure that vulnerable people were identified and received the support they needed. Elderly residents from a care home in Keswick were evacuated as the floodwaters rose. Children's services coordinated a school closures programme and supported vulnerable young people. County Council staff assisted at reception centres and the council's catering unit provided food.

Recovery

Inspection of roads, buildings, potential landslides and bridges.

Removing waste and debris, stripping flood damaged properties, providing skips and free waste collections and increasing recycling centre capacity, including temporary onsite recycling centre at Cockermouth.

Children's services addressed safeguarding issues regarding children made homeless.

Community engagement officers attended a series of meetings with voluntary local flood action groups to offer on-going practical help and support. One lesson learned has been the value such groups can add and the need to work with them to maximize this. The number of Flood Action Groups has increased from 12 to 30.

Getting business going again is vital both in terms of economic contribution to wellbeing in general and to enable people to buy food etc. Advisers worked with around 300 businesses. Environmental health officers advised on food safety, contaminated food disposal, refurbishment issues and pest control.

Environmental protection teams ensured contaminated land issues in relation to a temporary supermarket, bridge and station in Workington were processed exceptionally quickly to provide these vital services as soon as possible.

SLDC provided a special room at a council depot for residents providing a washer, dryer, fridge, microwave, kettle, cutlery and toaster.

Emergency accommodation was arranged by the district councils' housing teams.

South Lakeland District Council's homeless team and environmental health officers carried out home visits to identify the needs of vulnerable people.

District council building control surveyors worked flat out to assess homes in flood-affected areas to allow people to return as soon as possible. In Allerdale over 700 properties were inspected for any signs of serious structural failure.

Outcomes
There has been no evaluation of the work undertaken, either in general or from a public health perspective, but clearly much of it was work that simply had to be done to avoid deaths and other unacceptable consequences. One measure of the success of the recovery operation as a whole was that the helplines set up be Allerdale and SLDC were able to be closed down by the end of November.

In the short-term the major health outcomes were the prevention of disease outbreaks as a result of sewage contamination and food poisoning. In the short-medium term health inequalities arising from the relative inability of poorer and older citizens to overcome the transport problems to access food, work and services were addressed. In the longer term it seems reasonable to assume that a significant wellbeing benefit has been achieved for the area as a whole by aiding a speedy economic

and social recovery and through the resilience demonstrated by the communities.

Alcohol misuse – Gateshead, South Tyneside and Sunderland

Gateshead, Sunderland and South Tyneside Councils are working together to create long-term partnerships to improve social outcomes and make efficiency gains in relation to alcohol and drug misuse. The project is working towards a multi-disciplinary approach to families most at risk in 'hotspot' neighbourhoods, aligning work to change social attitudes and behaviour around alcohol misuse, and better collaboration across the three Crime and Disorder Reduction Partnerships.

The challenge
Gateshead, South Tyneside and Sunderland have double the national rate of hospital admissions for alcohol-related conditions. Only 5 per cent of dependent drinkers in the North East are in specialist treatment – the World Health Organisation (WHO) estimates this should be 15 per cent.

Local estimates are that the total cost to the economy in the three localities is £214 million, with the cost to the public sector alone estimated at £143 million. Health treatment is a large element of that cost - NHS spending on alcohol-related conditions in the area is around £33m.

The proportion of crime across the area which is related to alcohol is estimated at 15 per cent (the equivalent for drug-related crime is 2 per cent). A third of residents expressed concern about drug and alcohol related problems. Local research also supports national figures that families most at risk can cost up to £100,000 a year over and above the costs of benefits and supports.

Action

Gateshead, South Tyneside and Sunderland identified that shared priorities around reducing anti-social behaviour and alcohol-related harm can be addressed more effectively by coordinating service delivery across the three localities. Work is focusing on three priority initiatives: a multi-disciplinary approach to families most at risk in 'hotspot' neighbourhoods; aligning work to change social attitudes around alcohol misuse and expanding the use of brief interventions; and better collaboration across the three Crime and Disorder Reduction Partnerships (CDRPs).

The councils are working with partners to mainstream existing initiatives - such as on Gateshead's National Family Intervention Project Pilots and the 'Team around the Family' model – which put families at the centre of service delivery, remove duplication and focus on longer term prevention. Resources are being targeted towards neighbourhoods with high incidence of activity in relation to alcohol and drug misuse. These 'hotspots' have been identified by working directly with communities enabling the council to identify not just those areas where Police recorded incidents of crime (mainly in city/town centres), but also part of neighbourhoods where anti-social behaviour was of particular concern to communities. This, together with improved data sharing across agencies to help identify high end service users, has allowed partners to deliver targeted coordinated, family-centred interventions to those most in need.

The three councils work with community leaders to agree ways that communities can contribute to reducing alcohol misuse and share responsibility for changing attitudes and behaviour. In Felling, the neighbourhood management team is working directly with the local community to 'co-design' local activities and responses to reinforce the social marketing campaign being led by Balance (a partnership of agencies in the north east working together to address alcohol issues). In Harton Moor, one of the 'hotspots', a community charter around drug and alcohol misuse is being devised - this will set out the offer from service providers and what residents will do to contribute to tackling alcohol and drug misuse.

CDRPs across the three localities are coming together come together to deliver an Integrated Offender Management model. Partnerships will work together to develop systems and protocols, revised job descriptions, links to other services and quality and performance standards. The Integrated Offender Management project will act as a pilot, designed to lead to integrated working in other areas of CDRP work.

Outcomes

The three councils are working with the Institute of Local Governance (a collaboration between all north east universities) to thoroughly evaluate pilot activity and ensure an evidence-based approach is taken.

Extending the multidisciplinary approach to families at most risk could achieve savings of up to £7m over the next 3-5 years.

Evidence from social marketing initiatives and the expansion of brief interventions in relation to tobacco, indicate that a similar coordinated approach in relation to alcohol consumption could account for a 5 per cent improvement. A 5 per cent reduction in NHS spending on treating alcohol-related conditions in the three localities would represent £1.6m. A 5 per cent reduction in alcohol-related crime would save £5.4m. The Department of Health (DH) suggests that using brief interventions across the three localities could represent a £1.2 million saving.

The pilot integration of offender management will release £200,000 from 2010-11. The aligned set of initiatives across the CDRPs aim to reduce the total cost of alcohol misuse across the three localities by 10 per cent within five years; broadening integration and collaboration across the range of CDRP activities could release resources of up to £1.8m per year.

Liverpool Smokefree Kids

Liverpool City Council has worked in partnership with health services to deliver a range of coordinated projects to change social norms around smoking to reduce levels of smoking and protect children from second-hand smoke.

The challenge

Although comprehensive smokefree legislation is in place, smoking remains the biggest cause of preventable disease and major contributor to health inequalities.

Liverpool has made considerable progress in tobacco control however there remains an urgent need to protect children from second-hand smoke and reduce smoking amongst young people. The challenge within the city is to denormalise smoking and raise awareness of the harm caused to children by second-hand smoke.

Action

SmokeFree Liverpool (SFL) was formed to address the significant health inequalities attributed to smoking and second-hand smoke. This unique partnership is co-chaired by a cabinet member from the council and the chairman of Liverpool Primary Care Trust (LPCT) and works to a local strategy signed off by the leader of the council and the jointly appointed director of public health.

SmokeFree Kids involves council and public health staff as well as commissioned services from third sector organisations. The initiative has been predominantly funded through the Area Based Grant, with support for specific strands either through PCT funding or support in kind e.g. management costs absorbed through existing organisational structures. Senior officers participate in decision making through either Stakeholder Advisory Group (executive

officers) or Management Group (operational managers).

Social marketing techniques are used to promote the SmokeFree Kids brand, alongside targeted activities and projects.

D-MYST is a youth advocacy group which aims to deglamorise and denormalise smoking. It lobbies on issues that concern young people and undertakes smoking prevention initiatives in schools and youth associations. D-MYST is currently campaigning for SmokeFree movies and Liverpool City Council carried out a public consultation around this to consider local licensing restriction for films that contain smoking.

The Alcohol and Tobacco Unit is a ground breaking team, based within the council's Trading Standards Team and is funded by LPCT. It focuses entirely on consumer protection issues concerning alcohol and tobacco; this includes targeting retailers who sell tobacco to children and providing 'knock back' training to retailers to help them comply with legislation in relation to underage and proxy sales.

SmokeFree Families is a project jointly funded by the council and LPCT. This scheme aims to protect children from second-hand smoke. The project is managed through Children's Services and works routinely through Sure Start Children's Centres that also fund a stop smoking adviser, providing stop smoking support for parents of young children.

Schools have been instrumental in success of SmokeFree Kids. All primary schools display a SmokeFree Kids banner and members of staff have participated in training to enable them to deliver personal health and social education classes that include smoking prevention. Secondary schools engage with D-MYST and have also been part of a European project investigating the role of peer to peer training for smoking prevention.

Liverpool Women's Hospital and Alder Hey Children's hospital have facilitated events to promote SmokeFree Kids and more specifically SmokeFree Families.

Outcomes
Smoking prevalence has reduced in Liverpool from 35 per cent in 2005 to 28.2 per cent in 2009.

In 2007 smoking took place in 34 per cent of Liverpool households with children. By 2009 this had dropped to 25 per cent.

In 2008 smoking took place in 5 per cent of cars carrying children; in 2009 this had reduced to 2.4 per cent.

Co-ordinated activity between the council and partners has resulted in efficient campaigns that maximise resources and integrate health and wellbeing.

Working with businesses to produce healthier food – Norfolk County Council

Norfolk County Council is working in partnership with local producers to reduce the levels of salt in bread and sausages and rethink the role of local food businesses as custodians of health. The project has also identified savings for local producers and promoted local food by supporting producers to meet consumer demands.

The challenge

Heart disease, strokes and cancer cause about two thirds of deaths across Norfolk. Although levels of cardiovascular disease rates are falling, the level of inequality has been increasing steadily since 2000 and is forecast to continue to increase if current trends continue. If this doesn't change, by 2020 life expectancy in Norfolk may no longer be better than the England average and the difference in life expectancy across the county will have increased.

The impact of excessive salt consumption in terms of high blood pressure, heart attacks and strokes is recognised nationally and internationally. Analysis of existing research shows that 89 per cent of consumers in the region report healthy eating as being important to them, with the amount of salt in food registering as the top food specific concern. Simple changes to the way of life of individuals can reduce the risk of these conditions: figures from Consensus Action on Salt and Health (CASH) indicate that a 0.1g reduction in salt consumption per day equates to a 1 per cent reduction in the risk of stroke or heart attack, while the Food Matters report suggested that a 1g reduction in daily salt consumption could prevent 6700 premature deaths every year in the UK.

Action

The Health Improvement Management Group provided an opportunity for all Norfolk County Council services to identify work which impacts on health and wellbeing and link to NHS priorities. Salt reduction in locally produced food was recognised by all partners, including industry, as a crucial initiative. Initial analysis by the Trading Standards service identified two key areas of concern:

Craft bread. Bread is the largest source of salt in the UK diet, accounting for 17 per cent of consumption. Craft baked bread is produced throughout Norfolk, with loaves often exceeding government targets for salt content.

Sausages. Sausages are a particularly popular part of the Norfolk diet. Almost all Norfolk butchers produce sausages - but only 17 per cent meet national salt targets.

The Trading Standards service – with advice from the Regional Health Partnership - started working with local bakers and butchers and industry experts to understand the processes and demands on their businesses, explore existing good practice and identify workable, effective, sustainable ways that the composition of products could be altered to reduce salt levels without impacting on costs, product quality or consumer acceptance.

Local producers and industry groups (the National Federation of Meat and Food Traders, the British Meat Processors Association and the National Association of Master Bakers) were central to the design and delivery of this project. Research and work with experienced local butchers led to the identification of a new way of making sausages (the 'wet method') which reduced salt content by up to 20 per cent, produced sausages with a taste and texture preferred by two thirds of consumers, improved the microbiological safety of sausages, and was cheaper for butchers. Following trials by producers, experts and consumers, the new technique was championed by experienced butchers to their peers in conjunction with training at a local specialist college.

The project was delivered as part of a broader initiative to raise awareness of the relationship between salt and health across the county, including workplace events for council employees and events engaging with local communities (delivered with the local library service).

Outcomes

Norfolk found that salt levels in locally baked bread were as high as 1.73 per cent. Reducing this to the national target of 1 per cent would see a reduction of 0.63g of salt per 100g of bread consumed. For a man consuming the average amount of bread per day (99g), this would reduce the risk of stroke and heart attack by over 6 per cent.

The new sausage-making method being shared across the county could reduce salt content by as much as 20 per cent. A 20 per cent reduction in sausage salt content will remove 119 kg every week from the diet of Norfolk residents.

The reducing salt in sausages project has helped reinvigorate the Norfolk butchery trade by promoting local butchers as a healthy place to purchase meat products by using the 'Salt Aware Scheme' and promoting the initiative through local media. The partnership approach to working with local businesses and industry bodies – providing support to help smaller businesses meet consumer demand for foods lower in salt and working to understand the challenges and demands faced by these businesses – has also developed the relationship between the council and local businesses.

Norfolk County Council has been proactive in sharing the lessons learned across local government and businesses. The salt reduction in bread project has resulted in a national project coordinated by Local Government Regulation and delivered by councils across the UK, while the salt in sausages project resulted in the development of an online salt calculator which butchers can use to calculate (and alter) the salt content of their sausages.

Sheffield: Improving air quality and public health

Improving air quality is a health and wellbeing priority identified within Sheffield's 2010 Joint Strategic Needs Assessment as a key action to reduce health inequalities.

Challenge

Up to 35,000 die prematurely in the UK each year because of air pollution. Research suggests that people whose death is caused by air pollution die on average 10 years earlier. It has been linked to worsening of asthma, chronic bronchitis, heart and circulatory disease, and cancer. It disproportionately affects vulnerable groups such as children and older people and has a greater effect in areas of deprivation, increasing health inequalities.

Health and wellbeing in Sheffield is better than ever, but significant inequalities persist, with large numbers of people experiencing lower levels of health than the city or national average. National estimates of the health impact of air pollution translate locally into between 240 and 325 deaths brought forward each year in Sheffield, with estimated health costs of around £95 million per year. Within Sheffield's 2010 Joint Strategic Needs Assessment (JSNA), improving air quality is a health and wellbeing priority for two areas in the city, one of which has significantly lower life expectancy than Sheffield's average.

Action

As well as being recognised in the JSNA, air quality is included in other policies such as transport and planning, ensuring pollution reduction and associated health benefits are integrated into service delivery. The council also works closely with other authorities, businesses and community groups on specific projects.

The council leads the Sheffield Clean Air Partnership, working collaboratively with the Health Authority, Highways Agency, Environment Agency, local universities, Chamber of Commerce, black and other local community forums, South Yorkshire Passenger Transport Executive, bus operators and other groups to develop the air quality action plan for the area.

Air quality is a strategic priority for transport in Sheffield and the council has implemented a range of measures including more bus lanes; joining up cycle routes; free parking for registered low emission vehicles; and the first Statutory Quality Bus Partnership in England, resulting in operators using cleaner, less polluting vehicles.

The council is currently working with local companies and vehicle manufacturers on an innovative trial of biomethane vehicles, to demonstrate the benefits and are now introducing the vehicles to Sheffield City Council fleet, and establishing refuelling infrastructure, for which it now has a delivery plan. The biomethane, collected from organic waste, is supplied by a local business, helping to develop the local green economy as well as demonstrate leadership in reducing emissions from the council's own fleet.

By implementing low emission strategies through the planning system, Sheffield has secured funding and mitigation measures from new developments to help minimise transport emissions.

Sheffield works with the three other councils and the Passenger Transport Executive in South Yorkshire on the award-winning Care4Air social marketing project to inform people about air quality and promote behavioural change. The campaign provides individuals, organisations, schools and

businesses with information to enable them to 'do their bit' and runs an awards scheme that recognises champions and good practice.

The Care4Air partnership also runs the 'ECO-stars' fleet recognition scheme: a free, voluntary scheme designed to provide recognition, guidance and advice to operators of goods vehicles, buses and coaches. This reduces emissions and helps local businesses to increase efficiency, saving fuel and money.

The council works with the East End Quality of Life Initiative (EEQLI), which is funded by NHS Sheffield. EEQLI provides support to the voluntary and community sector in areas of Sheffield including those ranked as some of the most deprived in the country. They established a Community Air Pollution Monitoring Network in 1998 and local volunteers carry out pollution monitoring in their neighbourhood on a monthly basis.

The council is now working with NHS Sheffield on a feasibility study for an 'AirText' system. Air quality alerts provide free predictions of moderate or high air pollution incidents and related health advice to those with medical conditions that are exacerbated by air pollution, such as asthma, emphysema or angina. This information empowers people to manage their conditions more effectively, for example making sure they have their inhaler handy and that there is plenty of medication left in it when pollution levels are high.

Outcomes

The health impact of man-made air pollution in the UK is estimated to cost £8-20 billion per year, comparable to the cost of alcohol misuse to society. The figures are for the cost of premature mortality and do not include morbidity costs which result in significantly higher figures. The cost to Sheffield per year is estimated to be £95million.

By using the planning system the council has secured from new developments 32 electric vehicle charging points, 110 car park spaces reserved for low emission vehicles, subsidised bus passes, employee travel plans, car share schemes and £35,000 for air quality monitoring. By engaging with the private sector, the council gained free use of Mercedes Benz vehicles for its biomethane trial.

An evaluation of the ECO-stars scheme found that the scheme could help third party fleet operators achieve a 50 per cent reduction in nitrogen dioxide emissions and a 75 per cent cut in particulate matter, which is very harmful to health.

There are also obvious benefits of helping people with conditions affected by pollution to manage their own exposure through schemes like AirText, such as reduced GP and hospital visits. One in five of the population suffers from respiratory or cardiovascular complaints that can be made worse by air pollution. Research on the AirText system in London showed that 94 per cent of users found the service useful or very useful and 71 per cent of people changed their behaviour as a result, for example avoiding outside exercise.

Sheffield is working with the other authorities in the Low Emission Strategies Partnership to develop a toolkit which will allow robust quantification of low emission measures on a particular fleet or development providing a much stronger evidence base for actions.

Bristol – 20 mph speed limits in areas of high health inequalities

Bristol City Council and NHS Bristol are jointly piloting two large 20 miles per hour (mph) limits in parts of the city with higher health needs. They are accompanying this with a persuasive and upbeat communications strategy to raise people's awareness of the health and social benefits of lower traffic speeds. As well as fewer injuries and deaths, other potential benefits could include more physical activity, less traffic noise and better air quality, which can lead to reductions in obesity, diabetes, heart disease and mental health conditions.

The challenge
The Marmot Review – Fair Society, Healthy Lives – states that "targeting [20mph] zones in deprived residential areas would help lead to reductions in health inequalities". The link between people from poorer backgrounds and casualties from road accidents has been observed from at least as early as the 1980s (see the Black Report published in 1980 by the then Department of Health and Social Security). More recently, modelling 20mph speed limits in London found that the number of casualties in the most deprived quintiles would be halved (a fall of 580 deaths annually).

So, reducing motor vehicle speed in deprived areas saves lives. However, it is often residents in more affluent residential urban areas that successfully lobby for 20mph limits, with deprived areas continuing to have the higher speed limit of 30mph.

Reduced speeds also enables residents to walk, cycle and socialise within their local community without fear. Doing this in areas of deprivation is likely to have an even bigger impact because numbers of road casualties/ deaths, levels of physical inactivity and levels of deprivation are linked. This raises the possibility of improving long-term health outcomes by increasing physical activity and reducing sedentary lifestyle diseases such as diabetes, obesity and heart disease.

Action
As part of scoping work for the Active Bristol project – an ambitious five-year programme to reverse the decline in physical activity of the city's residents - partners identified a blanket 20mph speed limit on residential streets as one of the main things they wanted to achieve.

City councillors – both the previous and current administrations – have authorised two large pilot 20mph areas. The south Bristol pilot began in May 2010; the eastern area will start this autumn.

The approach will use a combination of speed signs, social marketing and communication. No physical traffic calming measures – such as chicanes and speed humps – will be installed.

The council and PCT put forward two reasons for this.

The first is cost. Even before the global economic crisis and UK recession they had identified that money simply would not be available to install physical traffic calming devices across all of the city's residential areas.

The second is that an approach based on culture change and underpinned by communications will in the long term mean that physical measures are not necessary. By providing people with factual information about why they are installing 20mph speed limits and what the benefits will be, they hope to build on what they have already identified as strong public support.

The communications teams of the PCT and council are developing a joint campaign to highlight the benefits of 20mph limits where people live. It will emphasise that the limits will help to make streets pleasant, safe and friendly. The approach will draw on the following evidence:

• reducing speeds to 20mph won't affect journey times

• a child that is hit by a car at 40mph has an 85 per cent chance of dying – if they are hit at 20mph that risk plummets to 5 per cent

• lower speeds reduce air and noise pollution

• public support for the new speed limit is very strong – the local Twenty is Plenty campaign is backed by all of the organizations that make up Bristol Partnership, Living Streets, Streets Alive and Sustrans.

The campaign will target both the public and the workforces of the council and the PCT. Staff behaviour change alone could have a significant effect: community nurses drive an average of 3,500 miles a day on Bristol roads – by setting an example and driving at 20mph in the pilot limits they will act as 'pace cars' and help to ensure that other drivers keep to the speed limit too.

The PCT and Council are speaking with local police officers through neighbourhood partnerships to make sure that the new limits will be monitored. The Bristol Partnership – the city's LSP –is fully signed up to 20mph; the Assistant Chief Constable of Avon and Somerset Police is a member of the partnership board.

To complement the pilots the Council and PCT have set up a knowledge transfer partnership with the University of West of England. This is exploring how the council can move away from a model that looks only at reducing the number of casualties and deaths from road accidents/crashes (which could, for example, be achieved by keeping children indoors) to an approach that is based on reducing road danger.

Outcomes
The first pilot is now being evaluated. This includes both measurements of whether or not people are keeping to the new speed limit and qualitative research with residents to gauge their before-and-after views regarding the limits.

The results of the project are not yet published (September 2010), but it will suggest a number of practical measures. For example, traffic authority approvals (TAAs) are circulated internally as part of the consultation on new traffic schemes. The simple form gives officers an opportunity to comment on the proposed scheme. In future, the project is recommending that the TAA form should include the following questions:

• Does this scheme promote walking or cycling?

• If so, how?

• If not, why not? And why should it still be approved?

The purpose of these questions is to help change the transport engineering culture, which traditionally has prioritised motor vehicle use and flows ahead of any broader understanding of the health impacts of failing to provide for active travel modes. For example, research has found that there is a significant association between commuting to work by car and being overweight or obese compared with active travel modes and using public transport.

Timescales for monitoring and evaluation are still being developed, but it is likely that councillors will make a decision on whether or not to roll out a blanket 20 mph speed limit in residential areas by the middle of 2011.

If the pilot results echo research and practice elsewhere then the potential for improving health and reducing health inequalities is promising. The innovative aspect – and the big unknown – is whether a combination of speed signs and social marketing and information support will be enough to change behaviour in two ways: reducing the speed at which individuals drive, and encouraging them to consider using active travel modes (walking, cycling, public transport).

The 20 mph pilot limits are costing £430,000 to implement, which is being spent on signage, vehicle-activated warnings, traffic regulation orders and evaluation. An alternative approach of installing traffic calming measures would run into the millions. The budget for the accompanying communications strategy is not yet fixed.

The pilot speed limits are part of a wider approach to embedding a healthier transport system across the work of the Council and the PCT. Under the joint director of public health, Bristol has a Healthy Urban Team that includes a senior planner, a public health specialist and other cross-cutting experts.

Widespread 20mph speed limits will be opposed by the motoring lobby in much the same way that tobacco companies resisted legislation to protect people from the health impacts of secondhand smoke. Slowing down vehicles to protect people from the harmful consequences of motor traffic may lead to improvements in the places where people live. One consequence could be an increase in cycling and walking, less car use, more use of car clubs and, perhaps, fewer cars. That is a worry for the motoring industry.

References

Campbell, F (Ed) for Local Government Improvement and Development (2010) The social determinants of health and the role of local government. London: LG Improvement and Development

HM Government (2010) Equity and Excellence: Liberating the NHS. London: The Department of Health

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., Geddes, I. (2010) Fair Society, Healthy Lives: A strategic review of health inequalities in England,post-2010. London: The Marmot Review

The Local Government Group is made up of six organisations which support, promote and improve local government.