Local Government Association

Public Health England

Public health transformation nine months on: bedding in and reaching out

Foreword

The Government's public health reforms have radically shifted power to local authorities, empowering them to invest and innovate to improve the health of their communities. The reforms reflect the Government's confidence that local communities are best placed to respond to local needs, rather than central government.

The case studies in this document demonstrate that local government is enthusiastically embracing the new opportunities of the public health reforms, and imaginatively responding to local issues. I look forward to seeing many more such examples of local energy and innovation in the months and years to come, and seeing the measurable impact it will have. The challenge for us all is not just to identify good practice, but to champion and share it.

Jane Ellison MP, Minister of Public Health

The fundamental changes to the public health system which went live last April have been embraced with tremendous enthusiasm by Local Government. In effect, public health has 'come home' and, as the examples included here so clearly demonstrate, they have seized their responsibility for improving the public's health and reducing inequalities with vision, vigour and considerable creativity and innovation.

Courageous leadership is critical to effecting meaningful change and it is particularly heartening to see that public health teams are reporting excellent access to local politicians whose talent and local knowledge is being brought to bear in creating lasting partnerships within and across communities. Their first hand awareness of what is needed on the ground and how to build the partnerships that can most effectively make things happen is beyond price.

A key message from the case studies is the opportunity for local authorities to develop their role as public health bodies, who consider the health impact of every policy decision they make and every service they commission. This was what lay at the heart of the decision to repatriate the responsibility for improving the public's health from the NHS to local government. No other part of the public health system is better placed to break down barriers and work across the boundaries. These case studies show this is well under way.

Duncan Selbie, Chief Executive, Public Health England

I would like to thank the local councils that contributed case studies for this helpful and timely publication. I continue to be struck by the passion and enthusiasm of councillors, officers, clinicians and local communities to make the new public health system work. Many people have talked about the return of public health to its natural home in local government but I think the agenda is far more radical. It is about developing a new culture in which health is at the heart of integrated planning and services, in which all parts of the council and all of the providers delivering services on the councils behalf understand how they can contribute to better public health outcomes.

Bringing the analytical rigour of public health professionals to bear on the information and insight councils have about their local populations is surely one of the great opportunities of the next few years. We know that our current health and social care system is unsustainable and will buckle under the weight of demand unless we re-engineer our planning and service provision to promote healthy choices, protect health, prevent sickness and intervene early to minimise the need for costly hospital treatment.

Councillor Sir Merrick Cockell, Chairman, Local Government Association

Introduction

Public health made the formal transfer to local government in April 2013, and in the subsequent months great strides have been made to tackle the wider social and economic determinants of poor health. This resource commissioned by the LGA and PHE describes how public health in a number of councils has started to use the opportunities of a local government setting to improve health and wellbeing.

The case studies were chosen because they show a range of ways in which public health in councils is approaching its new roles. They include councils spread across England, covering both rural and urban environments and with varying levels of deprivation and affluence.

The detailed case studies (below) provide key messages from the area, a description of the work they are undertaking to best meet local health priorities and plans for the future.

Themes

A number of themes have emerged from the case studies.

Council welcome
Those councils in the case studies universally expressed the view that public health had been enthusiastically welcomed by the politicians, managers and workers of the council who were keen to be involved in health improvement. If there were any pockets of resistance, where people had not yet made the links between health and wider determinants, these were small. Directors of public health were equally enthusiastic about the opportunities presented by working in a local authority.

Embedding public health across the council
It is striking how many local authorities are taking a whole-council approach to public health, based on an understanding of the interconnectedness of the social determinants of health. Areas were taking a variety of approaches to this, sometimes in combination.

- Other departments taking on responsibility for indicators in the public health outcomes framework (PHOF).
- A bidding fund from the Public Health Grant for other departments to undertake public health tasks linked to the PHOF.
- Hub and spoke – small senior team with the rest of public health dispersed across the council, with consultants as members of senior departmental management teams.
- A public health department with additional responsibilities (eg leisure, environmental health, licensing and trading standards).
- The Director of Public Health takes on wider roles in the council eg Deputy Chief Executive, Director of Adult Social Services, Director of Children's Services or 'Commissioner for People', ensuring that public health is at the centre of the council and all its functions.

- Public health department deploys relationship managers across other departments.
- Processes to ensure that all relevant policies, decisions and investments across the council would contribute to health improvement.
- Systematic changes across the council eg a shift to assets-based approaches.
- Strong links with district councils, including grants, to help them deliver on the Public Health Outcomes Framework e.g. affordable warmth measures and to contribute to the mandatory public health functions.

Relationships with politicians

All areas reported good or excellent access to local politicians. This applied to council leaders and elected Mayors, politicians with a lead role in health and wellbeing, to other portfolio holders, to health scrutiny and to all members of the council. There were several examples of councillors actively engaging with the public health agenda. Public health teams in most of the case study areas have contributed to development work with councillors and key council staff (both senior management and frontline staff) to help them understand the public health remit and the links with other core local authority services.

Some described a steep learning curve on how to operate in the council – even those who thought they had a good understanding found that it was more complex than they had expected. Some described a different dynamic now that they were in the council: there was more trust from being part of the organisation and understanding the political context, but there were also more requirements – for instance, more emphasis on taking into account the priorities of citizens and of budgets.

Two-tier areas

County councils in two-tier areas are developing a range of ways of engaging district councils in the public health agenda (many district councils have, of course, already developed programmes of work to address health issues and tackle health inequalities). Following the transfer of public health to county councils, public health teams are using one or more of the following to involve district councils

- making grants available to district councils through a bidding process
- delegating some of the public health commissioning functions to district councils
- operating a devolved public health system with public health specialists allocated to district councils, either geographically or organisationally or both
- developing joint work programmes to tackle health inequalities involving key district council functions such as housing
- at a governance level, offering places to district councils on health and wellbeing boards and/or setting up county-wide public health committees with district council representatives.

Partnerships with the NHS

Relationships with clinical commissioning groups (CCGs) were described as very good. The fact that public health was now in the council did not seem to have thrown up any barriers – possibly because individuals were already well known or because public health was still seen as an independent voice. The Director of Public Health or their representative usually attended the CCG board. Public health was sometimes seen as having a broker role for discussions between the council and the NHS. The 'core offer' to the NHS was seen as providing an opportunity to influence CCGs' commissioning towards greater prevention and addressing

health inequalities. Some queried whether the same level of trust would continue when individuals moved on and public health became more associated with the council. A small number of CCGs were described as not switched on to the public health agenda, and areas were aware they would have to work on this.

Neighbourhood and assets-based approaches
Some areas were working with the council's neighbourhood and community-based activity to make health and wellbeing improvements at a local level. This often involved Local Area Coordination and Assets Based Approaches which identify the capacity, skills, knowledge, connections and potential in a community and assist people to build on these to make the improvements they themselves have identified as important

Improving health and wellbeing support
Most areas were looking at maximising the impact of their support for community health and wellbeing and where possible integrating this with other services such as housing and benefits advice. In taking this approach, some were moving away from a traditional approach to individual lifestyle and behaviour and giving a greater emphasis to the wider social determinants of health. It was noticeable how many public health staff referred, for example, to the impact of the recession on health and to broad themes such as worklessness and its effect on mental health and wellbeing. Some areas stressed that investment in public health was an investment in the economic and social wellbeing of local people.

Some have already set up referral and self-referral services based around a community wellbeing programme. Several mentioned that their overall objective was to ensure that the local authority becomes a 'public health organisation'. Measures to bring this about included developing programmes for staff across the council under the rubric 'health is everybody's business', training frontline staff under the banner of 'making every contact count', ensuring that consideration of health impact is built into the planning process and developing training programmes for community health trainers recruited from the communities they serve.

Some areas were now seeking to find ways of joining up all elements of the health and wellbeing intervention spectrum: targeted interventions, neighbourhood support, lifestyle services and wider support that tackles the social determinants of health such as debt advice.

Scoping, evidence base and research
All areas were using evidence, research and best practice to develop and integrate their services; a few had also undertaken their own research, for example on long-term behaviour change, mapping food outlets in neighbourhoods and risk reduction for long-term conditions, which was contributing to major policy change.

Regional and sub regional developments
Case study areas involved in regional developments indicated that these were continuing and were re-energised through the role of councils which have strong regional associations. Councils sharing a footprint are also working together on joint initiatives.

For example, the Association of North East Councils and the DPH network work closely with Fresh, the North East's office for tobacco control and Balance, the North East's alcohol office both collectively commissioned by the 12 local authorities. Recent initiatives include:

- babyClear – a collaboration between stop smoking services, midwives and foundation trusts to ensure every woman smoking during pregnancy is given full information and encouraged to quit

- Balance undertook a large consultation with feedback from 15,000 people on the Government's alcohol strategy which found support for minimum alcohol pricing.

Main challenges

The main challenges mentioned related to the poor financial situation, particularly:

- the need to try and maintain a focus on public health while savings were needed across all council departments, and also in the NHS
- the impact the recession was having on the poorer members of society.

Some areas were using parts of the Public Health Grant to offset council savings and maintain services that contributed to public health outcomes.

Several areas were starting to focus on the impact of poverty, particularly in terms of use of food banks, child nutrition, mental health and debt and promoting a 'living wage'.

Key messages

Some of the messages from case study areas from considering the case studies as a whole include the following.

- Local authorities now have an opportunity to develop their identity as public health organisations, with corporate awareness of their health impact embedded at every level of the council: developing this identity needs an explicit strategy.
- Public health initiatives should be regarded as an investment in the social and economic wellbeing of the local area.
- Local research is extremely helpful for local prioritisation, and can also contribute to the national agenda. It provides an opportunity to bring together public health analytical skills with local government data collection and project implementation experience.
- District councils are important allies for public health in two-tier areas, in supporting both mandatory and non-mandatory public health commissioning and services.
- Local government can influence health improvements at the national level by lobbying based on local knowledge.
- Local area coordination and assets approaches are excellent vehicles for health and wellbeing improvements at a neighbourhood level.
- Co-location in the council's main offices is important so that public health can be involved in both formal and informal discussions.
- Improvements cannot be made all at once; there needs to be a phased approach in which new ways of working are developed and embedded.
- Sharing public health funding with responsibilities for the public health outcomes framework (PHOF) is a useful way of achieving ownership of health across the council.

The case studies

Bedford and Central Bedfordshire – developing a proactive 'core offer' and a corporate role

The three unitary authorities in the county have a joint DPH. A proactive approach is being taken to the 'core offer' to the NHS. Public health is developing a corporate role in helping identify health impacts of council activities and prioritising action.

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Blackburn with Darwen – social determinants of health fund and lobbying for national change

The council has established an investment framework for the Public Health Grant which involves a shift from a medical to a social model, and uses the World Health Organisation's tool for evidence-informed decision making in public health.

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Brighton and Hove – a pioneering multi-faceted approach to alcohol misuse

A number of partnerships and a strategy involving a parallel inter-linked range of initiatives have been set up to tackle the increasing problem of alcohol misuse in the city. Pioneering use has been made of the council's traditional functions in the service of health. Involving the public and service users has been a key component.

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Derby – integrated behaviour change

Proposals for a major shift in health and wellbeing services have been supported by local evaluation and national evidence. A person-centred approach to behaviour change is demonstrating improvements in terms of individual satisfaction, health outcomes and cost effectiveness.

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Devon – a health website for the whole community

Development of an interactive JSNA has been used as an opportunity to open up information and accountability to the community, enabling data to be used by community groups. The website is monitored and continually updated.

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Dorset – an inclusive county-wide approach

The county has a public health team covering three upper-tier authorities in a three-year arrangement with a pooled budget. The new arrangement is a good test bed for other joint working, eg on integration of health and social care.

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Durham – asset-based approach through Area Action Partnerships and regional co-ordination

The county council is taking a phased approach to embedding new ways of working into opportunities for improving health both locally and regionally.

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Hartlepool – public health department with additional council functions and targeted health improvement interventions

The new Public Health Department includes environmental health, trading standards, licensing and sports and recreation. Interventions are shaped by local research as well as national evidence and their impact on health is regularly monitored.

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North Lincolnshire – integrated public health and strategic public health outcomes fund

Sharing public health funding with responsibilities for the public health outcomes framework (PHOF) is proving to be a useful way of achieving ownership of health across the council.

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Staffordshire – connecting with communities, partnerships and assets including business and universities

Moving to become a 'strategic commissioning council' whose work is based on improving outcomes, building on assets and using a 'local action: central support' operating model to tackle wider determinants of health at a local level.

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West Sussex – a DPH with a strong corporate commissioning role

As the council moves towards a stronger commissioning role, the DPH is now the 'Commissioner for People', bringing new resources to the council and highlighting synergies with other council functions such as social care. Certain public health commissioning functions has been devolved to district councils and joint work with district councils is taking a lifecourse approach to housing and homelessness.

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York – multiple additional roles and extended influence

Combining the roles of director of public health, director of adult social services and deputy chief executive puts public health at the heart of all council activities and beyond.

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Case study

Bedford Borough Council and Central Bedfordshire Council: developing a proactive 'core offer' to the clinical commissioning group while embedding in local government

"We have been able to use the skills Public Health brought to the Central Bedfordshire Council very effectively in the re-procurement of our leisure services. Public Health has helped us develop a service specification which ensures that the provider engages with the more vulnerable groups in Central Bedfordshire to help reduce health inequalities."

Councillor James Jamieson, Leader, Central Bedfordshire Council

"We welcome the opportunity that Public Health moving to the council has given. As well us using public health skills and resources to improve health for local residents, the core offer to the clinical commissioning group (CCG) has provided an opportunity to work together with the CCG to improve outcomes particularly for children and older more vulnerable residents. We have been able to challenge and influence each other to really make a difference, for example, the action we need to take to reduce the number of people dying prematurely."

Dave Hodgson, Directly Elected Mayor, Bedford Borough Council

Key messages

- Public health is working with Bedfordshire Clinical Commissioning Group (BCCG), the local area team and commissioners within Bedford Borough and Central Bedfordshire Councils to prioritise the health and social care needs of the population and ensure an evidence based approach to commissioning services.
- The public health team is beginning to embed within both Bedford Borough and Central Bedfordshire councils. A key stand of work is in identifying synergies with traditional local authority functions that can be aligned with public health functions to achieve the best outcomes for the residents of each council area.

Context

Central Bedfordshire

Central Bedfordshire, a predominantly rural location, is home to about 260,000 residents. The population, which is ageing, is expected to increase to 274,400 by 2016 which has implications for future health and social care needs. Average life expectancy at birth is increasing and is currently 79.5 years for men and 83.0 years for women, similar to East of England and better than the England averages. The life expectancy gap between the most affluent and most deprived areas is

on average 5.5 years for women and 7.4 years for men. Also, some disadvantaged groups have lower life expectancy. People in the more deprived areas die earlier predominantly due to diseases of the circulatory system, cancers, especially lung cancer; diseases of the respiratory system and diseases of the digestive system.

Bedford Borough

Bedford Borough is a unitary authority with a population of approximately 159,200. It is estimated that this will increase to more than 170,000 by 2021. There are up to 100 different ethnic groups living in the borough and the Black and Minority Ethnic population make up 28.5 per cent of the total population. Average life expectancy is comparable to the England average but there are large inequalities. The difference in life expectancy between the least and most deprived wards is 11.3 years for males and 9.1 years for females.

Organisational structures

The two authorities (Bedford Borough and Central Bedfordshire) share a director of public health. There is one CCG covering both councils. The CCG divides itself into five areas, which it calls localities. These are: Bedford, Chiltern Vale, Leighton Buzzard, Ivel Valley and West Mid Bedfordshire. Bedford Locality covers approximately the same area as Bedford Borough Council, while the other four localities form the area covered by Central Bedfordshire Council.

The director of public health has built a strong public health team within each unitary authority. For reasons of consistency, effectiveness and economy of scale, there is also a 'core public team' working across the two local authorities. The core team provides health protection, health care public health, commissioning of prevention programmes and health intelligence functions and delivers much of the core offer to BCCG.

The 'core offer' to the NHS

The 'core offer' to clinical commissioning groups is a mandatory function of local authorities, as outlined in the Health and Social Care Act 2013. The 'core offer' provides public health advice, information and expertise in relation to the healthcare services that they commission.

The leaders and chief executives of the two authorities and the director of public health believe that this 'core public health offer' to the NHS allow local authorities to have a really significant role in influencing CCGs' strategies and reducing health inequalities.

The following are examples of how this has taken place:

Public health staff have developed reports for Bedfordshire CCG to suggest that they can make significant impact on hospital activity around chronic obstructive pulmonary disease (COPD) and asthma by improving a range of prevention measures including improving the uptake of immunisation for influenza in both the over 65 and the under 65 'at risk' groups. This message was well received by the CCG's Executive Committee which then identified 'flu vaccination as a key area to target amongst all its commissioned services and a vital strand of work in trying to achieve a reduction in hospital activity.

The Public Health team has also worked closely with BCCG to develop 2014/15 commissioning intentions using the priorities identified within the Joint Strategic Needs Assessments (JSNA) for both Bedford Borough and Central Bedfordshire councils. A year long programme of consultation and prioritisation with varied groups of stakeholders led to a robust set of commissioning intentions. The public health team supported BCCG in this process by providing an analysis of the evidence base and an in-depth understanding of the health needs of the population together with methodologies for prioritisation and resource allocation.

A Locality Profile has been developed for each of the five localities of BCCG. The focus of the profiles was to segment the population and identify the specific population health needs of each locality around the five major killers: cardiovascular health, respiratory conditions, diabetes, cancer and stroke. These profiles then helped localities prioritise primary and secondary prevention as well as early diagnosis using NHS Health Checks within the commissioning plans for the localities. The locality profile was also helpful for clinicians for each of the disease areas to target interventions to deprived communities where outcomes could be improved.

The Public Health team worked with both clinicians within BCCG and senior officers within local authorities and developed a joint approach to Public Health England's 'Longer Lives' programme of work developed in response to the Secretary of State's call to reduce mortality rates for major killers such as cardiovascular disease and stroke. The public health team worked with the chief operating officer of BCCG and other senior officers within Central Bedfordshire Council and presented an action plan to Central Bedfordshire's Health and Wellbeing Board. This approach resulted in prioritising actions to tackle premature mortality by all members within Central Bedfordshire Health and Wellbeing Board including the local councillors who are very keen to prioritise the prevention and early identification agenda across all business within the local authority.

The public health team has worked with BCCG to develop specific CQUIN (Commissioning for Quality and Innovation) objectives around Making Every Contact Count (MECC) for all health care providers including the two major acute trusts. This will help embed prevention and early interventions and support behaviour change where required.

The public health team is working jointly with BCCG on a pilot project to reduce health inequalities. The pilot project aims to identify a range of support networks available to GP practices to meet the multifaceted needs of their practice populations. This project also involves a new level of engagement with the public, community and voluntary organisations and local authority colleagues, and will assist GP practices in providing a well measured package of health and wellbeing interventions for their patients. This project has had engagement from senior leaders within Bedford Borough Council including the elected mayor.

Relations with councillors and within each local authority

Within both the local authorities, the public health team has carried out a mapping exercise of current local authority work against public health outcomes, to identify synergies across directorates and focus work in those areas which could have the greatest impact on improving the health and wellbeing of the residents of Bedford Borough and Central Bedfordshire councils.

Priority areas for action

The public health team is beginning to make links across council departments in developing the priority areas for the Joint Health and Wellbeing Strategies (JHWS). A large proportion of key actions have been identified around the wider determinants of health. An example around this is the work that has been identified in relation to educational attainment and skills, looked after children and people on low incomes.

The aim of the public health team going forward is to continue to raise the profile of population-level outcomes, embedding language and understanding of public health across both the local authorities as well as BCCG.

The team aspires to engage councillors as champions of health within local authorities.

The team would also want to influence clinicians who are commissioners within BCCG to be aware of the social determinants that impact on the health of the population. The team aims to do this by bringing forward evidence, comparator data, and facts and figures with particular emphasis on improving health outcomes and reducing health inequalities.

Future plans

As part of a corporate approach to making Central Bedfordshire Council a public health organisation, a focused piece of work is planned, based on where the council can have the greatest impact in relation to children in poverty and inequalities across a wide range of indicators, including those relating to mental health.

Bedford Borough has also identified the health and wellbeing of children and young people as a priority in its Joint Health and Wellbeing Strategy, along with improvements to safeguarding and action to maximise the independence of older people and improving care and choice at the end of life.The team is engaged in developing and implementing 'Make Every Contact Count' MECC charter in both local authorities .This charter outlines a commitment to ensure MECC principles of using brief interventions to make lifestyle change a core business of health and social care service providers across both local authorities, as well as BCCG and partner organisations, including the voluntary sector.

As part of the work on integrating health and social care, the public health team is working with BCCG and commissioners of adult social care of both local authorities to commission lifestyle hubs for the residents of Bedford Borough and Central Bedfordshire councils. These hubs will bring together health, social care and other council services through an integrated approach making lives of people with long term conditions easier and improve their outcomes.

The public health team is developing health inequalities assessments at a GP practice level and recommendations for action. This function will aim to deliver on BCCG's statutory requirement to deliver on tackling health inequalities and help target interventions to improve the health and wellbeing of deprived communities

The team is developing locality profiles with phase two outlining the health of children. These profiles will help commissioners across health and social care identify key priorities for these vulnerable groups for small geographical areas within each local authority and BCCG locality.

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Case study

Blackburn with Darwen Borough Council: social determinants of health fund and lobbying for national change

"Delivering improved public health outcomes for residents is one of the councils top priorities. We have made a very good start this year at ensuring that it is not just 'another service' – but that it is at the heart of everything we do across policy, service delivery and decision making in the council. As we head into our second year we are exploring what it means to be a public health council – not just a council with a public health service. Many of the factors that affect the health for our residents are determined by national policy – in areas such as welfare reform, food policy, tobacco control and alcohol pricing. We therefore see national advocacy for health promoting policy (supporting the most vulnerable) as a growing part of our local public health role".

Councillor Mohammed Khan OBE, Deputy Leader and Executive Member for Public Health and Adult Social Care

"Local government expenditure is actually a mix of taxpayer cost and investment. The dedicated Public Health Grant is clearly an investment as it both delivers improved citizen health outcomes and reduces avoidable costs to health and social care later on. Non-health local government budget spend areas – leisure services, education, children's services, regeneration, housing – can all bring 'added public health value' if undertaken in ways which address the Marmot Report's areas of evidence-based health improvement action outside the healthcare system. One legitimate use of the Public Health Grant is to find ways to lever governance and accountability for health outcomes from these non-health cost centres."

Dominic Harrison, Director of Public Health

Key messages

- Public health initiatives should be regarded as an investment in the social and economic wellbeing of the local area.
- There is potential for local government to influence health improvements at the national level by lobbying based on local knowledge.

Context

Blackburn with Darwen is a unitary local authority with a population of around 148,000. Almost 20 per cent of the population is Muslim, the third highest level in the country. The health of people in Blackburn with Darwen is generally worse than the England average and deprivation is higher, with around 9,000 children living in poverty. The difference in life expectancy is around 13 years for men and seven years for women between the most and least deprived wards. Early deaths from cancer, heart disease and stroke have fallen, but at a lower rate than the national average.

Blackburn with Darwen Council, Public Health and NHS have a long history of close partnership including a Care Trust Plus. Around twenty public health staff came to the local authority, where the Specialist Public Health directorate is part of the Adult Services directorate.

Public health investment and accountability across the council

Blackburn with Darwen has established an investment framework for the Public Health Grant which involves a shift from a medical to a social model, and uses the World Health Organisation tool for evidence-informed decision making in public health.

New ways of working in Blackburn with Darwen's public health operating model include:

- 'Health Included in All Policies' (HIAP) – a health impact assessment process to ensure all relevant policies decisions and investments in each directorate contribute to health improvement, eg through the development of existing staff.
- A £1 million Social Determinants of Health Fund invested for two years across all council directorates so they can take direct action on health improvement.
- Public Health Delivery Agreements which commit each council directorate to delivery against the Public Health Outcomes Framework (PHOF).

This approach spreads both investment and accountability for delivery against public health outcomes across the council, and has generated useful discussion about the use of mainstream funding for health outcomes. Because of the budget cuts facing the council, some of the fund has been used to count against further savings to continue to provide services that have been identified as having a strong evidence-base for improving health and wellbeing. For example, contributions to the falls service and to children's centres.

Public Health Delivery Agreements will involve formal contracts involving two main requirements:

1. Each directorate is responsible for five outcomes from the PHOF as an added value to their existing activity and investment. For example, the outcomes for the Resources Directorate (shared with some other directorates) are:
    - children in poverty
    - 16-18 year olds not in education, employment or training
    - households in temporary accommodation

- self-reported wellbeing
- reducing mortality from causes considered preventable.

The Resources directorate will contribute to these outcomes through their range of general and targeted advice services.

2. Each directorate is also responsible for additional PHOF outcomes through interventions agreed as part of the Social Determinants of Health Fund. For example, the Regeneration directorate is responsible for 'killed and seriously injured casualties on England's roads' through road safety team interventions including existing 20mph zones.

   A development next year will be to identify proxy indicators which show how directorates contribute to shared and overarching outcomes such as reducing child poverty.

   Performance against the outcomes will be monitored quarterly in each directorate through existing council systems; additional support and oversight will be provided by the Portfolio Holder for Public Health and the Director of Public Health.

Integrated health and wellbeing service

Blackburn with Darwen has been reviewing its stand-alone health and wellbeing services to identify how these can best meet local health priorities in the most cost effective way. An integrated health and wellbeing service, to be launched in January, has been designed with the following key features:

- Targeted at people with long term conditions who are high users of health and social care services (eg unplanned hospital admissions), may be subject to health inequalities, and may have multiple lifestyle risk factors which can benefit from health and wellbeing interventions.
- A single point of access Wellbeing Hub which will receive referrals from GPs and another professionals, and self-referrals. The hub will be staffed by health trainers offering a holistic assessment and, dependent on need and what people want to achieve, may provide:
  - brief intervention and advice
  - signposting to an appropriate service, with follow-up to ensure successful access
  - a lifestyle consultation with a health trainer and personalised guidance and support
  - reassessment and follow up as appropriate.
- Services that can be provided through the Hub tackle both healthy lifestyle and the wider determinants of health such as: sustainable neighbourhood services, decent and safe homes, one stop shops and 'advice for all', drug and alcohol services, falls prevention, self care, stop smoking, weight management and physical activity. Services also have their own 'front door' for direct referrals.

Lobbying for national change

Blackburn with Darwen councillors are committed to looking at what needs to change in the national picture in order to bring about local health improvements. Issues in which they have been involved include:

- the full council agreed to support and lobby for a minimum unit price for alcohol
- the council is looking at the potential for ethical investment in pension funds
- using local public health experience to inform national debate through research based publication.

Also, shisha bars are a growing leisure pursuit in Blackburn with Darwen as in many towns and cities; shisha bars are unregulated but represent potential public health hazards such as infection. The council is lobbying for more effective local authority control over these venues and for these to be put on the same footing as alcohol.

Integrated commissioning

Public health is involved in integrated commissioning both across the council and with the NHS. With adult and children's services, it forms part of the newly formed council Integrated Commissioning Team, and provides expertise in intelligence, data analysis and evidence based interventions.

It provides a similar role in the Integrated Commissioning Group that operates with the CCG. For example, borough-wide mental health services have been reviewed with a view to commissioning services with more focus on early intervention, prevention, timely and easy access for GP referrals for anxiety and depression, and community based services. Public health advised on the evidence base for the service specification and also contributed funding for advice and counselling.

Future plans

GPs in Blackburn with Darwen are federating into groups of practices sharing services and resources. This provides an opportunity for integration with the council's neighbourhood delivery model. Public health is involved in brokering discussions on how this can be achieved, including links to the Better Care Fund.

Public health has identified evidence of a significant crisis emerging from the recession and from welfare reforms; there has been a massive increase in referrals to food banks, child malnutrition has doubled and there is an increase in mental health problems. It will be important to identify and measure the extent of these problems and to work with others to identify ways of taking action. The Specialist Public Health directorate's chosen charity for 2014 is the local food bank.

Public health will have a role in identifying the health impact of fracking which will be tested in the area.

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Case study

Brighton and Hove City Council: a pioneering multi-faceted approach to alcohol misuse

"The balance between the health costs and economic benefits from the sale of alcohol is an issue that we in Brighton and Hove have been tackling head on since public health was brought into the local authority. On the one hand the estimated local annual health, social and crime costs from alcohol total a substantial £107 million, on the other hand the annual economic turnover from its sale is estimated at a massive £329 million.

"We have a local partnership which brings together health, police, licensing, elected members, local universities, the voluntary sector and a leading supermarket and local public and bars. Our jointly agreed work tackles four areas: the drinking culture, the night-time economy, alcohol availability and early identification, treatment and aftercare of alcohol disorders. The initiatives described in this case study have helped deliver tangible results such as the number of alcohol related hospital admissions falling for the first time in many years."

Dr Tom Scanlon,
Director of Public Health

"We are determined to get the balance right between the economic benefits to the city of alcohol and limiting the serious harm it causes. By working in partnership with key city agencies and not being afraid to think outside the box, Brighton and Hove has been at the forefront in terms of managing our night-time economy."

" 'Sensible on Strength' is a classic example because it has had a high take-up by off-licences voluntarily. High-strength drinks are a breed apart from other beers and ciders and can cause immense harm to vulnerable people.

"This initiative is just one of many we have pioneered that demonstrates the vital role that public health plays within local government."

Councillor Rob Jarrett,
Chair of the Health and Wellbeing Board

Key messages

- In tackling a multi-factorial and multi-sectoral issue like alcohol or drug misuse, a cross-council, corporate and partnership approach is essential.
- Embedding public health within the council facilitates the pioneering use of traditional council functions in the service of health.
- Involving the public and service users has been a key component in the success of the approach.

Context

Over the last several years, over-consumption of alcohol has been an increasing problem in Brighton and Hove. A number of factors contribute to exacerbating the problem.

- There are two universities and therefore several thousand additional young people in the city during term-time and much of the holidays.
- Brighton and Hove have become a significant tourist destination for pleasure-seeking, mainly young, travellers.
- The city has a disproportionately high number of pubs for its size.
- It has recently become known as a place for about-to-be-married couples and their friends to engage in hen- and stag-night revelry.

Within Brighton and Hove, the impact of alcohol is considerable. Rates of alcohol-related Accident and Emergency attendance and hospital admissions continue to increase year on year, and in the Big Alcohol Debate, run by the council across the City in 2012, 36 per cent of respondents were worried about the effect alcohol has on people in the city. Each week in the city there is an average of:

- 66 ambulance call-outs due to alcohol
- 46 attendances at Brighton A&E department related to alcohol
- 11 people under the age of 25 years seen by Safe Space, a service supporting those who are too inebriated or injured to get home
- 97 alcohol-related inpatient hospital admissions for adult residents of Brighton and Hove
- two deaths associated with the impact of alcohol (almost one death a week wholly related to alcohol).

The costs to Brighton and Hove of alcohol misuse are estimated at £107 million per year: £10.7 million due to the health impact, £24.5 million due to economic effects and £71.8 million as a result of crime. Alcohol is also an important contributor to health inequalities.

- It is a recognised paradox that households in more deprived areas are less likely to drink at increasing risk levels, but more likely to experience alcohol-related mortality.
- Alcohol-related attendances at A&E are 50 per cent higher in city residents from the most deprived quintile compared with hose in the most affluent quintile of the population.
- Lesbian, gay, bisexual and transgender people living in the St James Street and Kemp Town areas of the city are more likely to drink alcohol than those in other areas;
- Alcohol also plays a part in tenancy breakdown and evictions within hostel accommodation, leading to a cohort of revolving door clients with complex needs who are not moving on to greater independence. Sixty per cent of those evicted from hostel accommodation in 2011/12 had alcohol misuse issues and 52 per cent of those evicted were evicted for an incident or incidents which took place when they were under the influence of alcohol.
- People with severe and enduring mental illness are three times more likely to be alcohol dependent than the general population.

A multi-pronged approach to tackling alcohol issues

It was clear that a very broad-based approach would be needed to tackle the problem on several fronts. Approximately three years ago a multi-agency Alcohol Programme Board was set up to address the issues. The Board includes representatives of public health, the NHS, the police, the council's licensing department and the drinks industry. Under the Programme Board, four domain groups were set up:

- addressing the drinking culture
- availability of alcohol
- the night-time economy
- early identification, treatment and after care.

Each of the domain groups has an action plan owned by partners throughout the city. At each meeting of the Alcohol Programme Board, there is a report back from each of the domain groups. The Programme Board feeds directly into the Health and Wellbeing Board. Both Boards are chaired by the Director of Public Health.

Impact of the transfer to local government

As far as tackling the alcohol issue is concerned, the move of public health to local government is seen as positive, making it easier for joint commissioning with other council departments to take place. For example the 'Equinox' service which works with street drinkers is jointly commissioned with the housing department. Another advantage is the co-location in one building of some public health staff with housing staff. Further examples of inter-departmental and partnership working are described below.

Working with licensing

In a pioneering approach to the council's licensing function, public health analysts have mapped the presence, use and impact of alcohol around the city in a Public Health Licensing Framework. The Framework gives data, provided by the Police and the NHS on alcohol-related or alcohol-fuelled crimes, ambulance call outs, A&E attendances and hospital admissions.

An agreement within the council and good working relationships between Public Health and Environmental Health where licensing is managed, ensures that all licence applications are seen and commented on by the DPH, who uses the Public Health Licensing Framework to assess risk. A strongly negative risk assessment may be given as a reason for refusing a licence. For example, Sainsbury's recently wanted to open a 'Local' branch in an area of high alcohol impact. The DPH's view, which the council accepted, was that a licence should not be granted. On refusal, Sainsbury's took the council to court. However, the council won the case and the Sainsbury's 'Local' was opened without a licence. As a result of constructive dialogue with the council and public health staff, Sainsbury's has opened another branch without a licence and has become a member of the Alcohol Programme Board. Recent discussions at the Board have focused on Gay Pride weekend and the possibility that Sainsbury's (and other supermarkets) might move their alcohol section to the back of their shop and refrain from cheap promotions during the weekend.

In a further cross-departmental collaboration, the Public Health team commissions six health trainers who are managed by Environmental Health. A pilot placement of a 'recovering health' trainer is currently under way, commissioned and managed on the same basis, to support people coming out of drug and alcohol treatment, for example in looking for work or education.

The cross-council partnership approach to tackling alcohol issues is now further strengthened by the location of the community safety team within the public health directorate.

The Sensible on Strength Campaign

As part of the Alcohol Programme Board's work strand to address the availability of alcohol, the council has launched a campaign called 'Sensible on Strength' to reduce the number of off-sales outlets selling high and super strength alcohol. There is evidence from other areas that people who don't drink such high strength drinks are easier for services such as the Equinox service for street drinkers to work with and support. Over seventy off-licences in Brighton and Hove have signed the agreement to date and it is now an embedded part of the licensing regime.

Involvement of the public and service users

A City-wide discussion about the impact of alcohol was initiated by the council in 2012 through the Big Alcohol Debate in which thousands of people participated through surveys, events and online activities. Many of the issues which have since been discussed and initiatives undertaken by the Alcohol Programme Board, arose during the Big Alcohol Debate and were seen as priorities by the public.

The public health team has commissioned a full-time service-user representative who is based at MIND. His remit covers both drugs and alcohol, he sits on the relevant Programme Boards and carries out consultations, for example with people living in hostels, when new initiatives are mooted. For example, a screening tool has been developed to identify unmet needs of alcohol misusers and the service-user representative is involved in piloting this tool among actual and potential service users.

In another initiative, the public health team, with the support of the local authority schools team is piloting a parental alcohol contract, based on the Swedish 'Effekt' model. This involves parents of young people under 18 making a promise not to give their children alcohol. The approach is based on evidence that introducing young people to alcohol early in the hope of teaching them to drink moderately does not work and is more likely to lead to drinking problems at a later age.

The good news

Although, as with many public health interventions, it is hard to isolate and assess direct impact, it is the case that alcohol-related crime and alcohol-related hospital admissions have been steadily falling in Brighton and Hove over the past five years.

Future plans

The council is re-tendering its substance misuse contracts which are due for renewal in 2015. The alcohol needs assessment carried out in 2010 is currently being refreshed as part of the Joint Strategic Needs Assessment (JSNA) and will include an equalities impact assessment. It is seeking a partnership bid for the whole recovery pathway, as this has worked well with other contracts.

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Case study

Derby City Council: integrated behaviour change

"The success of b-You under this Labour administration is down to the person-centred approach, and basing targets on individuals' priorities and aspirations for improving their own health. The service assesses patients and works with those who really want to change, and lets them focus on their area of concern first and tailors support to their needs. By also working with friends and family, an individual can really be helped on their journey to a positive, healthy lifestyle. Sessions are carried out all over the city, and will soon include the council's new multi-sports arena for access to a wide range of activities to support the service."

Councillor Mark Tittley
Cabinet Member for Adults and Health

"We have been involved with, and supported, b-You throughout its development and are confident of the health gains for Derby people as a result of the service."

Andy Layzell, Chief Operating Officer
NHS Southern Derbyshire CCG

"The work being done in the b-You service is great, and I'm fully on board with what they are trying to achieve, as are my fellow councillors. We are supporting by ensuring we understand how to intervene and make a referral for a resident in our ward area to ensure they receive support from b-You if appropriate. The improvements in health to Derby residents thanks to b-You is yet another great reason to be proud of Derby."

Councillor Paul Bayliss, Council Leader

"The growth of the b-You service is particularly exciting and innovative, with the introduction of a children and young person's element. The service is targeting children who are overweight and obese, but as a family approach so all members of a family can improve their health and their lives."

Adam Wilkinson, Chief Executive

Key messages

- Local piloting with independent evaluation has supplemented national evidence to demonstrate the benefits of a major shift in health and wellbeing services.
- A person-centred approach to behaviour change is demonstrating improvements in terms of individual satisfaction, health outcomes and cost effectiveness.

Context

Derby City is a primarily urban area with around 250,000 residents. The city includes a mix of affluent and deprived areas with a 12-year life expectancy gap and a significant deprivation-level gap between central and outer areas of the city. Derby is a young city with around half of the population aged 35 or less.

A public health team of around 30 people transferred to the local authority, and is located in the Adults, Health and Housing Directorate. The PCT and council worked closely together on health improvement in the build-up to the transfer and this enabled a major reform to health and wellbeing services – the b-You programme – to commence in April 2013.

b-You integrated lifestyle behaviour change

Background

Health improvement services in Derby were performing well on an individual basis, but they were also fragmented and did not facilitate a holistic approach to improving individuals' health. Therefore £1.5 million funding from different health and wellbeing programmes was pulled together into a single commissioning pot to provide an integrated health and wellbeing programme covering alcohol reduction, stop smoking, physical activity, and weight management. The evidence for the programme was based on a range of sources including a range of NICE public health guidance and behaviour change theory as developed in the UK through MINDSPACE behavioural economics at the Institute for Government.

It was also underpinned by the evaluation of a pilot set up by Derby PCT and carried out by Derby Council leisure services between 2011 and 2012. The pilot focused on long-term behaviour change for people at medium to high risk of serious ill-health. It offered a 12-month personalised programme providing motivational support for patients with a high BMI to help reduce calorie intake, develop sustainable physical activity, reduce alcohol consumption, and manage long-term health conditions. People who wanted to quit smoking in addition to losing weight were supported to do so by their advisor but smoking alone was not a referral criteria for the pilot. The evaluation demonstrated significant positive outcomes, all of which were far above performance from individual health and wellbeing services:

- 91per cent retention rate
- 6 per cent average weight loss (against an NHS target of 5 per cent)
- 97 per cent attended sports centres
- 100 per cent increase in activity levels
- 93 per cent improved health and wellbeing
- 100 per cent satisfaction with the programme.

Commissioning

In light of the above, the PCT, working with the council, agreed to mainstream and extend the integrated behaviour change approach across the city.

Due to the size of the contract, the PCT went to external tender under Official Journal of the European Union (OJEU) rules. The contract was won by the council's leisure services and commenced in April 2013 for three years with an option for a further two years.

Key points of the programme

b-You is person-centred and based around individuals' priorities and aspirations for improving their own health. For example, smoking may be the major health risk for an individual, but if he or she is more concerned/motivated to reduce their weight this would be where the programme would initially focus. A large part of the success of the programme is a result of the service assessing patients at referral and working with those who show a true readiness to change.

A b-You advisor will work with an individual (and their family/friends) to provide tailored support around that individuals need. The advisor will initially provide intensive support to develop and implement an individual action plan to help them on their journey. The support will gradually reduce when suited to the individual to allow them to make positive lifestyle choices independently.

The programme is carried out in a range of community venues such as children's centres, community centres, libraries and leisure centres with a specific focus on venues in deprived areas of the city. In the future this will also include the council's new multi-sports arena incorporating a velodrome, with access to a new swimming pool and a wide range of leisure activities. 97 percent of people in the pilot started to use sport centres for the first time – a significant achievement.

The programme is continuing to grow, with a newly developed children and young people's component. This targets children between the ages of seven and seventeen who are overweight or obese, through a whole family approach. This will enable positive behaviour change for the family as a unit.

The programme has changed since the pilot; referrals have been widened beyond GPs to include self referral, midwives, school nurses, clinicians from the acute sector and mental health services to target people who may have high levels of need, for instance as a potential alternative to weight-loss surgery. The CCG does not provide funding, but has been involved in and supported its development; a paper will be submitted to the CCG board providing evidence about the health gains to the people of Derby. In future it is hoped to develop a hub and spoke model around GP practice clusters with b-You advisors supporting local practices.

Due to its success, there have been suggestions to widen the interventions to include, for instance debt advice or keeping warm. However, while b-You advisors will refer people on to appropriate support, it is felt that at the current time it needs to focus on its core elements rather than expanding its remit until it is fully established.

Initial results

So far, 2000 people have participated in the programme, largely people from the most deprived areas. The programme is evaluated quarterly using a standard evaluation framework. Information in the first six months indicates that b-You will reach 1500 four-week smoking quitters over the year. The latest data shows 84 per cent of participants successfully stopped smoking at four weeks, higher than the previous stop smoking service. However, the main health gains are in 12 month quitters, which the programme will be able to support and identify. That alongside a yearly figure for BMI reduction and improved healthy lifestyles will allow the cost benefit of the programme to be calculated. The six month figures suggest that the programme will be very effective both in terms of cost and health outcomes.

Other developments following public health transfer

Some examples of opportunities provided by the transfer include the following.

Use of intelligence, analysis and evidence base – public health has had input into the following areas:

- analysis of pathways around nursing provision, acute beds and discharge (unfortunately this has not been fully achieved due to national constraints on sharing patient-level data across health and social care, an issue Derby seeks to see resolved)
- analysis of heating needs of vulnerable groups for the council's housing hub
- development of consistent messages for all front line staff (NHS, social care, fire service, housing etc) to give out to tackle excess winter deaths.

Rolling out making every contact count (MECC)

- all councillors have received MECC training increasing their understanding of public health and equipping them to make brief interventions and referrals (where appropriate) in their contacts with communities.

Future plans

Derby is a member of the local area coordination network and since 2012 has run a local area coordination programme, in which people who are vulnerable due to age, disability or mental health needs are supported by local area coordinators to develop personal, family and community networks. There are many cost-effective opportunities for improving health through tying together neighbourhood approaches to develop support, including for people with lower level needs who would not be referred to b-You or the local area coordination programme, and these will be pursued; for example, b-You is seeking to identify community health champions.

Measures to improve children's health are being developed across the NHS and the council by a joint appointment in education and a public health consultant as head of commissioning. Derby is currently looking to a broader integrated offer for children and young people 0-19 taking in school nursing the forthcoming health visitor responsibilities.

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Case study

Devon County Council: a website to support collaboration and communication on health and wellbeing

"The website enables us to work alongside some of the key services that influence the health of our communities, such as environmental health, employment, housing, and air quality. Since the transition of public health to Devon County Council, the website has evolved to become a valuable source of information and communication tool."

Cllr Andrea Davis, Cabinet Member for Health and Wellbeing and Chair of the Devon Health and Wellbeing Board

"Through the JSNA, we can collaborate more effectively with our colleagues in the Clinical Commissioning Groups, district councils, providers and communities to ensure what we are doing secures the best health outcomes for those who most need it."

Dr Virginia Pearson, Director of Public Health

"The county council's role, as a champion and leader for its local communities puts us in an ideal position to deliver the government's vision for a fitter, healthier society that doesn't rely on long-term health and social care services. Our Health and Wellbeing site enables us to bring together a wealth of information to help us to address some of the health inequalities that exist across the county."

Phil Norrey, Chief Executive

Key messages

- Development of a living and interactive JSNA offers huge opportunities to provide information that can be used by many different groups and communities of interest and to be more open to scrutiny and challenge
- A website that fulfils this role needs to be monitored and continually updated and promoted in the community.
- Open access to information by the community and transparency about health and care planning should be at the core of local health and wellbeing agendas.

Context

Devon is the third largest county in England, with the twelfth highest county population – about 770,000 residents. It has a dispersed rural population mainly centred on the 28 market and coastal towns and the City of Exeter. However, nearly a quarter of the population live away from the biggest settlements, presenting the challenge of providing services that are equally accessible to all. The population is older than the national average. This older group is expected to grow significantly, with people over 65 expected to make up over a quarter of the population by 2031. The county has a very small minority ethnic population well below the national average. This presents the challenge of ensure that the small minority ethnic groups

are seen as integral to the county and are not disadvantaged or excluded in any way.

The health of people in Devon is generally better than the England average. Deprivation is lower than average, however about 17,700 children live in poverty.

Life expectancy in Devon is higher than in comparison to England and Wales: 87.5 years in the ward with the longest life expectancy and 74.7 in the ward with the shortest. The commonest cause of premature death is coronary heart disease (which has been reducing in line with national patterns), followed by lung cancer. Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average. The level of alcohol-specific hospital stays among those under 18 is worse than the England average. Levels of teenage pregnancy, breast feeding and smoking in pregnancy are better than the England average. Estimated levels of adult 'healthy eating' and physical activity are better than the England average. Rates of hip fractures, road injuries and deaths, smoking related deaths and hospital stays for alcohol related harm are better than the England average. The rates of incidence of malignant melanoma and hospital stays for self-harm are worse than average.

Maximising use of information and data

When the transfer of public health to local government was mooted, commentators suggested that one advantage could be bringing together local authority population data with public health data analysis and modelling skills. In Devon, leading up to the transfer of 30 public health staff, it was decided that this opportunity could be built on, not only to create an up-to-date Joint Strategic Needs Assessment (JSNA), but also to make the information that informs the JSNA both visible and suited to many uses by many different constituencies. In the months leading up to the transfer, public health and local authority staff worked together to review the existing JSNA, to consider and assess examples of best practice across the country. They aimed to draw on these examples to create a multi-purpose website for the Health and Wellbeing Board that would also be a community resource.

It was decided that, to reinforce its status as an independent resource that resulted from partnership working, a separate website would be created away from the county council's website and with its own identity and branding. The website now contains information on Devon's Health and Wellbeing Board, including the usual minutes and agendas, but also briefing papers produced for the Board, the Joint Health and Wellbeing Strategy (JHWS), Annual Public Health Reports, JSNAs and a library of strategies, plans, needs assessments and other reports and information relevant to health and wellbeing in Devon. The website also hosts the Devon Health and Wellbeing newsletter, produced regularly, which gives news about the Health and Wellbeing Board, the CCG and local Healthwatch; and is used to promote consultations and relevant events such as Devon's hosting of the Rural Health conference.

The county council and partners already had strong place-based information and community health and wellbeing profiles which are posted on the website. They include:

- constituency profiles
- town health profiles
- local authority profiles
- NHS locality profiles
- GP practice profiles

Posting profiles which cut across each other means that they can be used for a variety of purposes and by different geographically based groups.

It was also decided to enhance this place-based information with information on different health topics or themes which, if placed in the public domain, would be of interest and use to different communities of interest. Each topic has a page on the website which outlines the issue, lists evidence of what works to tackle it (including NICE guidance where available) and relates it to the Devon context and what is currently being done in the county. Together, the pages cover a wide range of issues, including:

- issues around the wider determinants of health such as poverty and housing
- information on promoting healthy lifestyles, such as preventing unintentional injuries in children and young people, teenage pregnancy, skin cancer prevention and early diagnosis (a significant issue in Devon) and smoking
- improving the health and wellbeing of the population, including safeguarding adults and children, learning disabilities, homelessness and domestic and sexual violence and abuse

The website will be updated later in 2014 to include a new section on major diseases and conditions based on health needs assessments which are currently under way.

There are also sections on 'resources for professionals' and 'resources for schools', although care has been taken to ensure that all parts of the website are publicly 'digestible'. The intention has been to give the 'whole story' of an issue as part of the county council's and its partners' approach to open data both for professionals and for the community.

Information for the community

The Devon Health and Wellbeing website has been extensively used by and developed with input by community and voluntary organisations. The website has been promoted at over 30 public events across the county. Working with local Healthwatch, the public health team has taken groups of people through the website and drawn on JSNA community health profiles as a mechanism to discuss health and care issues with local communities. Health profiles and related JSNA information have been used in the preparation of community funding bids, and public events and website feedback has been useful in developing the website.

As a result, the website has a, perhaps surprisingly, large non-professional audience, with 16,300 separate visits during 2013. The public health team is able to get a flavour of the reasons for people's visits and the range of visitors, through a feedback mechanism that permits queries and responds to them. Queries have been received from community groups, people in education, including university students, schools and interested individuals.

Working with elected members

The website has been useful for introducing elected members to the new local authority health responsibilities and providing health and social care information for their communities. A number of briefing and awareness sessions have been run to ensure that the website is an informative and useful source of information for councillors. Elected members appreciate that the website enables the Health and Wellbeing Board and the health commissioning bodies to be open to scrutiny and challenge by providing information that is easily accessible and easily understood. They can drill down to look at the health profile of residents that they themselves represent as individuals, but also find information to help them develop policy (in the 'what works' sections) and monitor progress (in the 'what is currently being done in Devon' sections).

Support to the Health and Wellbeing Board and CCGs

Public health and other staff supporting the Health and Wellbeing Board believe that the website has really helped the Board to develop because it has been flexible enough to provide information for the disparate interests of Board members.

The website has also been important for the delivery of public health support to local Clinical Commissioning Groups and includes a number of resources for local health professional around health checks, local public health courses, along with CCG reports, performance indicators, maps and other documents.

Resources

The website was initially put together collaboratively by the council's web, public health and social care teams, and is set up so public health and social care staff can manage content and upload material directly. Promotion of the website at public events and feedback through its pages, along with similar work with councillors and local professionals, have assisted the public health team in tailoring website content to what people require. The public health team estimates that there is a net saving of time because people can be directed to relevant information on the website rather than ad-hoc analyses and reports having to be completed and sent individually.

The general shape and content of the website is steered by two JSNA groups – one group of technical officers and a broader JSNA development group which includes the local NHS, public health, the voluntary and community sector and local Healthwatch and gives a strategic steer.

Future plans

Further briefings for the themes and topics section of the website are currently being developed, including briefings relating to the characteristics protected by the equalities legislation and briefings on different long-term conditions for a planned 'major diseases and conditions' section.

Other planned developments include expanding and improving the library of documents, developing mapping and interactive reports, and making more datasets available to the public.

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Case study

Dorset County Council: an inclusive geography-wide approach

"The new arrangement across three councils is a good reflection of the collective will for broader joint working. For example, the three councils and the NHS locally have recently been successful in obtaining a £750,000 grant as part of the government initiative to transform the way health and social care services are delivered."

David Phillips, Director of Public Health

Key messages

- Three year agreement of all three authorities with pooled budgets.
- Critical mass of core staff to manage mandatory programmes and core functions.
- Alignment with other key organisational boundaries to support efficiencies in commissioning and delivery.
- Joint Health and Wellbeing Strategy structured for active consideration of both broader determinants of health and engagement of second tier authorities.

Context

Dorset has a population of 775,000 with population density varying widely across its districts, from 89 people per square kilometre in West Dorset to 4,000 per square kilometre in Bournemouth. The three top tier authorities have very differing demographic and health profiles, for example, Dorset County has one of the highest life expectancies in the country and some of the lowest premature mortality rates from heart disease and cancer and a population with an average age significantly above the national norm. Bournemouth by contrast has a much younger population with many students and tourists and has correspondingly different health indices; for example, it has the fifth highest premature death rate from liver disease in the country. The rapidly ageing population and the

effective prevention and management of the associated long term conditions are major challenges for all three local authorities.

Dorset now has a public health team covering three upper tier authorities: Dorset County Council and the borough councils of Poole and Bournemouth. The team is hosted by Dorset County Council on behalf of all three councils. This is a three-year arrangement, initially, with a commitment from all three councils to pool funds into a single budget on the understanding that it will be used for the benefit of all three.

The new arrangement is a good test bed for other joint working. Recently, for example, the county and borough councils and the local NHS successfully applied for a £750,000 grant as part of the government initiative to develop greater integration and new ways of working between health and social care. The public health team will play a key role in developing work on early intervention and prevention in this transformation project.

A further incentive to joint working across the three councils on public health issues is the fact that there is one Clinical Commissioning Group (CCG) covering the geography of the three authorities. Similarly there is one major community service provider and one local resilience forum, all of which helped make the decision to have one public health team much easier to make, with the potential for efficiency gains in future commissioning of services.

Furthermore, prior to the transfer to local government, there was already one public health team working across Bournemouth and Poole. Bringing this team together with the team for Dorset provides a critical mass which can deal effectively with the core public health functions as well as commissioning and delivering the mandatory programmes.

The new joint public health team has a director of public health, seven consultant-level staff and 35 other staff. Four of the consultant-level staff and four other senior staff have geographic as well as programme responsibilities. There are four assistant directors of public health, one for Bournemouth, one for Poole and two for Dorset, one of whom has special responsibility for the involvement of district councils. Feedback from the local authorities to this way of working has been positive so far.

Governance

There is a joint Public Health Board for all three partnership councils, but it was considered that one sole Health and Wellbeing Board would have been a "big ask", so at the moment there are two – one for Bournemouth and Poole and one for Dorset. However, for reasons of economy of scale and consistency across the county, there is one commissioning intelligence group delivering a county-wide Joint Strategic Needs Assessment (JSNA). The Joint Health and Wellbeing Strategy (JHWS) for each of the two Health and Wellbeing Boards is developed on the basis of the single JSNA plus local intelligence. The JHWS have been approached first by aligning outcomes along the lifecourse and then by aligning actions for those outcomes in a holistic, cross-sectoral way and finally by looking at the contribution of particular organisations and services. This approach allows a focus on people and places, consistent with recent local government thinking, rather than on specific conditions, technical areas or 'silos'. Initial feedback suggests that people have felt engaged and understand their roles better than was the case in local strategic partnerships.

To date, relations at the level of governance with the councils' overview and scrutiny arrangements and the way in which ongoing audit of public health activities is to be carried out across the participating councils are evolving. Sorting these arrangements out at an earlier stage, could, the director of public health believes, have lead to an even smoother transition to the new partnership

but given the time frame would have been very difficult. However, he is pleased that the new arrangements have delivered a 'critical mass' of public health staff with pride in their ability to sustain a professional service for the population.

The chief executives and leaders of each of the partnership councils have contributed to the positive spirit of the transition by welcoming their new public health function and demonstrating mutual respect for the public health team.

Prioritising interventions and equity for rural areas

As in other counties where services must be provided both within large cities or towns and across more sparsely-populated rural areas, the Dorset-area public health team must meet the challenge of equitable service provision.

One example of how equity for rural areas is being tackled is in the way in which priorities are set for Dorset's JHWS. The initial stage is to test potential priorities against the following questions.

- Is the priority expressed as a health and wellbeing outcome?
- Is there evidence that Dorset residents see the outcome as a priority?
- Is there much difference/variation between localities or different social groups in Dorset?
- Is there evidence that the outcome adversely affects those identified as being particularly vulnerable?
- In measuring the outcome, does Dorset compare poorly with other equivalent areas, or when compared with England as a whole?

Potential priorities are then tested against a scoring matrix.

Absolute numbers of road traffic collisions that result in serious injury or death are few when compared with the data that relates to other outcome priorities for Dorset. However, the impact of road traffic collisions on people's health and wellbeing can be considerable. Overall, rates of road traffic collisions that cause death or injury are significantly higher in Dorset when compared to England as a whole. It is thought that this is largely due to the extensive rural road network in the county. Of all the collisions that result in death or injury, the majority occur on sing-track rural roads. This is why reducing harms caused by road traffic collisions is one of the priorities of the JHWS for Dorset. The approach set out in the JHWS involves a number of council departments, including environment (road design and speed restrictions), planning (infrastructure development), licensing (reducing drink driving) and partners (police, NHS, communities). Communication within and between councils is vital for a coordinated and effective strategy and this is facilitated by the public health team's place at the heart of the Dorset area partnership. For cross-sectoral activity such as is needed to tackle issues like road traffic collisions, the concept of partnership is particularly useful. In trying to address complex problems, a broad approach is needed to tackle the multi-factorial causal nexus.

Involvement with district councils

There are six district councils within the county's boundaries. The director of public health and colleagues have had longstanding positive relationships will all key stakeholders in the districts. One district council has its own health improvement statement as part of its corporate plan and the public health team is encouraging the other district councils to do the same. Public health issues which have found immediate support among district councils are workplace health, housing

and the role of regeneration and tourism in promoting health and wellbeing.

Each district council and relevant locality GP rep is represented on the Dorset County Health and Wellbeing Board. The JHWS are written so as to ensure that each of the organisations and agencies are clear as to their responsibilities for various aspects of the strategy. Because of the close relationships between all the councils involved, it has been possible to organise these responsibilities more on a logical basis than on an organisational one. The public health team has been influenced by the idea of an 'ecological approach' focusing on the linkages between underlying causes of ill-health, health outcomes and interventions. Central to this approach is the idea of interconnectedness across agencies and across determinants, which highlights the need to involve all layers of local government as well as civil society in any response to public health challenges.

For example, one of the Dorset JHWS priorities is increasing physical activity and tackling obesity with an emphasis, in the relevant areas, on activity in rural settings. The public health team has worked on a programme with one of the district councils, in which the role of the public health team is to support and evaluate the programme, Activate 1000, with the district council leading on implementation. It was decided that, rather than providing funding directly, the public health team would assist with design of the programme and would support the district council in making a bid for a major lottery grant, in which it was successful.

Future plans

The partner councils see the public health challenge as being to translate the deliberations of the Health and Wellbeing Boards into sustained action at a more local level, especially in areas where both county and districts need to be involved.

In one example, a multi-agency approach is being developed to two key issues of concern for the local population: one disease area, chronic obstructive pulmonary disease (COPD), and one related environmental factor, housing. Key inter-relationships and linkages which may drive health and wellbeing outcomes for each issue have been identified and various indicators developed. Simulations of different policies in housing and COPD will be developed and their impacts on long-term health tested. The focus will be on learning how and what actions in the present can trigger plausible reactions and change in outcomes over time. The intention is that this will assist in ranking different policy options in terms of their acceptability or effectiveness. For example in the case of COPD, is it best to invest all resources in better treatment for the symptoms of exacerbations of the disease, reducing exposure to smoking and second hand smoke or investing in improved home thermal insulation to prevent temperature extremes?

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Case study

Durham County Council: asset-based approach through Area Action Partnerships, and regional coordination

"Transferring to the council presents the public health team with a great opportunity to work closer with our communities and focus on the issues that matter to them in relation to their health. In the past we tended to default to the medical / disease based approach to improving health but now at the council we are starting to get to grips with the real causes of poor health – the social determinants. It is a really exciting time to be in public health, although many of the challenges remain of course".

Anna Lynch, Director of Public Health

"Durham County Council is absolutely committed to helping residents take action to improve their health and we have demonstrated this by overtly signing a public health pledge at a full council meeting. We think our 14 Area Action Partnerships are a major force in working with us to achieve this".

Cllr. Lucy Hovvells, Portfolio Lead for Safer and Healthier Communities

Key messages

- The move to local authorities, with their wide range of responsibilities for people and places, provides new opportunities for improving health both locally and regionally.
- Improvements cannot be made all at once; there needs to be a phased approach in which new ways of working are developed and embedded.

Context

Durham County Council covers a population of around 513,000. Much of the council is rural, with 12 conurbations of more than 6000 people including Durham City with a population of 49,000. As well as areas of affluence there are deprivation and health inequalities in the county with a difference in life expectancy of eight years between different areas. Durham became a unitary council in 2009 and established a system of 14 Area Action Partnerships (AAPs), the purpose of which is to enable people in local areas to work with the council and service providers such as police and GPs to tackle local issues and to monitor the effectiveness of local services. Public health transferred from the PCT with around 40 staff, and is hosted within the Children and Adults Services Department.

Council-wide commitment to public health

Durham County Council has signed a pledge setting out how it intends to promote its ambition for all residents to enjoy health and wellbeing equal or better than the England average. This will be led by the public health team through measures including:

- working across the council to ensure all opportunities to improve health and wellbeing and reduce health inequalities are taken
- ensuring that action is based on research, best practice and current data
- working with partners such as the NHS, other local authorities and Public Health England to 'galvanise action'
- working with the AAP model to build on the strength and assets of local communities.

Asset-based approach in area action partnerships

Durham's AAPs are based on shared planning, community participation and coproduction with the council. Each has two levels of operation: a board involving seven councillors, seven public representative and seven partner representatives (e.g. council, voluntary sector, health, business) and a forum open to everyone who lives or works in the area. AAPs control a range of funding streams including influencing the spending of councillors' individual budgets, funding contributed by CCGs and public health, and elements of county-wide budgets such as Highways. There are regular grants programmes to stimulate community and voluntary sector action. In the latest programme, in which health is a theme, each AAP has between £20,000 to £60,000 in their fund, and applications are decided by public voting events – this is being rolled out across all AAPs following successful pilots in which hundreds of people turned up to vote. There is also a county-wide community chest fund focused on health and wellbeing (prevention and early intervention) which seeks to add value to AAP initiatives.

Public health has always worked with AAPs, but since transfer the relationship has become closer, and it is now supporting the partnerships to develop an asset-based community development model for health and wellbeing. An offer to AAPs has been developed which sets out what they can expect from public health, for example:

- Director of Public Health attends the board at least once a year
- a member of the public health team is aligned with each AAP
- public health will provide access to resources for health related programmes and campaigns
- public health will support the development of health-related funding bids.

The offer also describes what public health would expect in return, for example:

- the AAP will consider how to best incorporate specialist public health advice into its decision making process
- the AAP will become involved in public health related programmes and campaigns, including those linked with national campaigns from Public Health England (PHE) – an example of a previous campaign is plain packaging for tobacco.

Work with AAPs is at an early stage, but is more advanced in two areas in which initiatives are being developed with public health funding.

- In Shildon two community health workers will be commissioned to map assets in the AAP area and to establish community health champions.
- In Stanley a service is being commissioned to apply an asset-based community development approach to tobacco control (specification available from contact below).

These programmes will be evaluated with the intention of applying learning across all AAPs.

Other developments following public health transfer

The Public Health Team is aligned with departments across the Council. Some of the work they are engaged in includes proposals for:

- health impact assessments on all major policies
- an exclusion zone for fast food outlets near schools
- speed management policy of 20mph in areas with high levels of children's activity
- social marketing campaigns, for example on alcohol issues.

Public health across the region

The North East has a history of councils and public health working together on public health issues through the Association of North East Councils (ANEC) which took a proactive approach to the transfer of public health – identifying regional opportunities for change. Improving health and wellbeing is a major strand of ANEC's work and is undertaken jointly with the North East Directors of Public Health Network and Public Health England. Life expectancy in the North East has risen faster than in any region except London, but remains low overall, with high rates of early deaths from cancer and high levels of smoking in pregnancy. ANEC and the DPH network work closely with Fresh, the North East's office for tobacco control and Balance, the North East's alcohol office both collectively commissioned by the 12 local authorities. Recent initiatives include:

- babyClear – a collaboration between stop smoking services, midwives and foundation trusts to ensure every woman smoking during pregnancy is given full information about harm from a trained health professional and encouraged to quit
- large regional consultation fed into the Government's alcohol strategy consultation.

Future plans

Future priority areas include:

- shifting from lifestyle and disease models to holistic health and wellbeing services based on tackling social determinants across council functions
- considering pathways for reducing alcohol consumption and harm with partner agencies e.g. CCGs and police
- integrating health improvement services for children with early years services (when transferred to local authorities) and school nursing to develop a holistic service; this to be phased in starting with areas of highest health need.

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Case study

Hartlepool Borough Council: public health department with additional council functions and targeted health improvement interventions

"As Leader of Hartlepool Borough Council I am delighted that public health has integrated so effectively into the local authority. Since the council assumed responsibility for public health in April, this has provided us with a great opportunity to refocus our efforts to address the significant public health challenges across the town. I am confident that working in partnership with other organisations, we can make great inroads in improving the health and wellbeing of the people of Hartlepool."

Councillor Christopher Akers-Belcher
Council Leader

"Public health staff from the NHS have integrated very effectively into Hartlepool Borough Council since 1st April 2013. This has been possible as the staff had been located in the Civic Centre and the Director of Public Health had been a member of the Corporate Team for well over a year before formal transfer. Now public health has integrated into the authority, it has given us a great opportunity to expand the remit of the department to include public protection and sports and recreation."

Dave Stubbs, Chief Executive

"Joining the local authority has been a really positive experience for public health staff working in Hartlepool and we feel really embedded in the life of the council. Together with a range of staff in the local authority we are continuing our efforts to address health inequalities, improve health and protect the health of the population."

Louise Wallace, Director of Public Health

"I have worked very well for many years with colleagues in public health as part of our primary care trust. Since the 1st April 2013 when public health duties transferred to the local authority, the excellent working relationship has been maintained. As partners, we share a joint vision and strategy for health based on a comprehensive joint strategic needs assessment for the town. I am confident that together with health services, public health and social care we can make real improvements in health and wellbeing."

Ali Wilson, Chief Officer
Hartlepool and Stockton CCG

Key messages

- A Public Health Department including environmental health, trading standards, licensing and sports and recreation will provide further opportunities to achieve health and wellbeing improvements both strategically and on a day to day basis through front-line staff.
- Interventions are shaped by local research as well as national evidence and their impact on health is regularly monitored.

Context

Hartlepool is a unitary authority with a population of around 92,000. Overall, health, deprivation and life expectancy are worse than the England average and 5,400 children live in poverty. The difference in life expectancy in different parts of the borough is up to 12 years for men and 8 for women. However, early death rates for cancer, heart disease and stroke have improved in recent years.

Hartlepool has a long history of partnership working between the council, public health and primary care, with many health improvement initiatives in the council. Public health co-located in 2011 allowing functions to be embedded from an early stage.

Additional functions

Hartlepool Council went through significant structural and political changes around the time of the public health transfer.

Following a public vote, in April 2013 political arrangements changed from eleven years of a directly elected mayor to a system of council leader and committees. Council staff had to become familiar with the new ways of working, and public health joined in this process which proved a useful shared induction.

Around 15 members of the public health team transferred to the council and combined with the drugs and alcohol action team to become a stand-alone Public Health Department. Between April and June 2013 the council structure was reviewed, including discussions about the right range of functions to combine with public health. When this was decided, a phased approach of transfer took place:

- in September environmental health, licensing and trading standards joined the Public Health Department
- in January 2014 sports and recreation will formally come across (this is already happening in shadow form).

The Public Health Department will focus on the following key areas:

- health improvement
- clinical quality and commissioning
- drugs and alcohol service delivery
- sports and recreation
- public protection.

Many outcomes in the Public Health Outcomes Framework (PHOF) are owned by the Department, but others are shared with other council departments.

Opportunities from the additional functions

In recent years, council teams have worked with public health on a number of projects linked to the PHOF. Joining the Public Health Department will allow this to be extended throughout and beyond the organisation: at a political and strategic level, through the work of frontline staff, and through work with Public Health England. Interventions that are already in place or planned include the following.

Tattoo Hygiene Rating Scheme (THRS)
Hartlepool is working to introduce a hygiene rating scheme for tattoo studios in April 2014, and may be the first council in England to introduce this scheme. THRS is

a voluntary scheme supported by the Tattoo Piercing Industry Union and the Chartered Institute of Environmental Health. It is intended to increase safety standards and prevent 'scratchers', unlicensed tattooists working from home or places like pubs or festivals. The scheme promotes awareness of the difficulties of removing tattoos and the potential for health problems such as Hepatitis C, HIV and AIDS. Tattooists would be awarded hygiene grades of between 1 and 4 in a similar approach to the Food Hygiene Rating Scheme. All seven tattoo studios registered in Hartlepool have expressed interest in the scheme.

Linking tobacco control and stop smoking
Hartlepool received temporary IDeA funding to tackle a range of problems associated with illegal tobacco. A tobacco control officer in the council's trading standards section worked with partners in the Police and Customs and Excise to seize counterfeit tobacco, identify retail outlets supplying children, and ensure compliance with UK smoke free legislation and EU legislation on self extinguishing cigarettes (to reduce the potential for house fires). Public health funding has been used to continue this work. Also, having tobacco control and the commissioning of stop smoking services in the same department is expected to bring further opportunities for tackling smoking harm.

Reducing childhood obesity
Families in it Together Hartlepool is a partnership between the health improvement team, sports and recreation, the Dietetics Service and school nurses to provide a tier-two service for children identified as overweight or obese via the National Child Measurement Programme. The programme has been designed over a twelve-month pilot period and has changed in response to research and user consultation. The programme initially involved a group intervention with structured nutrition and exercise education but has changed to a behaviour change pathway with access to community support for individuals and families. The model will be launched in January 2014 and the first cohort of ten families will be monitored at 3, 6 and 12 month periods to measure sustained behaviour change.

Escape Diabetes Act Now (EDAN)
Following a scoping exercise, in October 2012 sport and recreation and the health improvement team implemented a 12 month pilot programme for patients identified as being at risk of Type 2 diabetes. The pilot has is based on NICE guidelines relating to Type 2 diabetes prevention, and involves:

- referrals from a GP practice based on clinical risk criteria
- interventions based on individual support and action planning, such as physical activity and nutrition
- measuring health indicators such as BMI, waist measurement, cholesterol and blood pressure.

Overall outcomes at six months shows a significant change to risk levels for the onset of diabetes as well as self reported increases in self confidence and esteem.

Mums on the move
This project has been designed following a scoping exercise that showed there were no accessible opportunities for pre or post natal physical activity. It was formed by a partnership of health improvement, sport and recreation, children's centres, midwifery service, the breastfeeding coordinator and the health visitor team. A range of tailored exercise is provided in council leisure centres and parks by trainers with additional training in maternity exercise. Also, each leisure centre has received the gold award for breastfeeding which involved training over 45 members of staff. Work is now underway to develop a specialist strand for the long standing (15 years) borough-wide exercise on prescription programme HELP to focus on maternal obesity, gestational diabetes and obesity resulting in infertility.

Application for early morning restriction order
The shadow Public Health Department recommended the introduction of an early morning restriction order (EMRO) for alcohol sales to reduce alcohol-related violence and anti-social behaviour in the town centre. The Committee did not support this at the current time but intends to revisit the issue next year to establish whether local licensees have taken responsibility for continuing previous improvements, including an in-depth look at the Best Bar None scheme. Although the recommendation was not supported at this stage, this was seen as a helpful political discussion on the potential of using licensing for health and wellbeing.

Long term conditions and older people
Public health is responsible for the falls service and winter warmth planning. It is contributing to integration planning for the Better Care Fund, with two public health specialists identified to be involved in designing programmes.

Future plans

Hartlepool is planning to work on two projects relating to takeaways in 2014-15, building on current work to reduce fat and salt content following the sampling of meals:

- a scheme to regulate the growth of fast food outlets working with planners and other partners and based around the 'takeaway toolkit'.
- the healthier catering commitment project, based on the London model for healthier catering commitment.

Hartlepool is considering the reconfiguration of a health improvement service for children 0-19 including school nursing, health visiting and, potentially, breast feeding services.

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Case study

Hertfordshire County Council: building a public health movement for the county

"We felt it important that public health had impact across the organisation and reached its population. Public health is key to our corporate ambition for our population to be healthier. Simply bringing public health over to do what it did without looking at opportunities across the council and the county was not what we wanted: transformation, not transfer."

Councillor Rob Gordon, Leader

"From the beginning the opportunity for public health to make a difference to our residents was clear, and we want to make that happen. Strong member leadership working well with high calibre officers and building partnerships across the county is one of our key principles, and it's paying off.

Councillor Teresa Heritage, Executive Member Public Health and Localism

"This is a fantastic opportunity to really get into the work we all want to do in public health to deliver sustainable improvement to population health. That requires some new ways of working as well as some solid traditional ways of working. We developed the "four engines" of public health model but equally from the start we realise that district and borough partners and our providers are essential to success."

Jim McManus, Director of Public Health

Key messages

- A strategic approach to building a 'public health movement' across the county is needed.
- The 'four engines' approach of public health – epidemiology/analysis, public health expertise, project management to deliver and commissioning – are all needed to deliver effectively.
- A broad and inclusive understanding of 'public health champions' enables staff such as environmental health officers to access public health resources.
- A mixed model for a public health structure ensures both dispersed and centralised expertise is available as appropriate.
- Strong partnerships for delivery and strong relationships with NHS and local authority are essential.
- Setting an example as a healthy employer with visible gains for staff is a helpful means of getting corporate 'buy-in'.

Context

Hertfordshire is one of the home counties (ie adjacent to London). It has a population of 1,116,000 approximately, with 20 per cent of residents under 16, 65 per cent of working age and 15 per cent aged 65 and over. In November 2013, the uSwitch Quality of Life index listed Hertfordshire as the third-best place to live in the UK. The health and life

expectancy of people in Hertfordshire is generally better than the England average. Deprivation is lower than average, although 30,000 children live in poverty. Life expectancy is 7.4 years lower for men and 5.3 years lower for women in the most deprived areas. The disparity in life expectancy between highest and lowest is 11.2 years. Over the last 10 years early death rates from cancer, heart disease and stroke have fallen and are better than the England average. Health priorities for Hertfordshire include physical activity and obesity, helping the expanding older population maintain their health and continuing to reduce levels of smoking.

The county council is the upper tier authority and there are 10 district councils. Two NHS Clinical Commissioning Groups (CCGs) commission health services for the county's residents.

The current director of public health has been in post for 18 months and transferred with 45 staff to the council in April 2013.

Governance

There is a Public Health Board for the county with membership from all the district councils. All members of the Public Health Board have contributed to the recently-published Public Health Strategy for the county which outlines priorities for 2013-2017. There is a statutory Health and Wellbeing Board which the director of public health and executive member for Public Health and Localism are members of, and a Public Health and Localism cabinet panel which joins together Public Health, sport, volunteering, localism and relationships with district and parish council local partnerships under one panel. These two member led fora work closely together. At officer level, a multi-agency Public Health Board was developed to involve a wider range of partners and give more detailed focus to public health issues than is sometimes possible at the Health and Wellbeing Board. The Health and Wellbeing Board and its strategy and the Public Health Board and its strategy share three common priorities, which Public Health leads on for the Health and Wellbeing Board – reducing the harm from alcohol, reducing the harm from tobacco and maintaining a healthy weight and increasing physical activity.

An inclusive approach to public health

In building a new way to do public health following the transfer to the county council, the director of public health, working with the chief executive took an inclusive approach. Public health is regarded as a family of professions which includes environmental health. Public health strategy and its implementation is conceived as being driven by four 'engines' within the council:

- a project management approach
- evidence and intelligence
- technical public health expertise
- commissioning and contracting.

The strategy is delivered through a 'mixed model', with some functions dispersed, some commissioned and others centralised according to their objectives. The use of agency powers by the council to ask district councils to deliver some functions is currently being developed.

The public health team's vision is of a 'public health movement' across the county within which public health is seen as 'everybody's business' (this is one of the priorities in the Public Health Strategy). A charter is being developed and every staff member in the county and district councils who signs up as a public health champion will have access to resources, including training, advice and support, subscription to relevant journals etc. The public health team is also developing an offer for the voluntary sector – to date half of the training commissioned by the team has been for staff in this sector. A separate workplace offer was launched in January 2014, which includes, for example, a master class on sickness absence.

Making the county council a public health organisation

The overall objective of the public health team, as far as being embedded within the county council is concerned is to make the council into a public health organisation. Eight steps are envisaged towards achieving this objective:

- a leadership committed to public health
- an understanding of public health challenges
- a clear strategy
- identifying what each area/department can do and developing the workforce
- identifying what public health tools and skills are available for use
- considering every area of the council's business systematically from a health perspective
- making the council an example of a healthy employer and service provider.

Each of these eight steps are backed up by an action plan developed with partners. Embedding the public health service into core business is also important – the director of public health is a sponsor for the leadership development programme for the council; the council's corporate policy and performance workshops in October 2013 focused on public health. In January 2014 the scrutiny function is asking every directorate how it is engaging public health in corporate and directorate objectives.

For example, in relation to the objective of being a healthy employer:

- there is a smokefree policy in place for employees which is moving to the next stage a Healthy Herts campaign for council staff has been nominated for two awards and can demonstrate a reduction in sickness absence
- a workplace health, counselling and wellbeing offer is available for staff, which includes gym discounts, workplace activities like walking, running and yoga and smoking cessation and other benefits
- the county council took part in the trial for the Stepjockey workplace wellbeing initiative and is now rolling it out across council buildings; during the trial, stair use by staff increased by 29 per cent from the baseline.

The action plans have 'buy-in' across the council and there is a corporate commitment to mainstream public health mindsets and approaches throughout the council's strategic thinking and activities. For example, at the workshops referred to above, discussion among public health and policy and performance staff and councillors led to a mutual understanding that ensuring the provision of warm, decent homes is a public health strategy and should be approached as such. It will require the county council, district and parish councils, the NHS and the business and community sectors to work together – one forum for making this happen will be the Health and Wellbeing Board.

Improving performance

The county is not complacent about its achievements in health care. It recognises that its performance on NHS health checks was well behind where it should be. A combination of public health expertise with project management and contracting expertise has seen a significant improvement in uptake and delivery of Health Checks with more being delivered in the first quarter of 2013/14 than the last two quarters of 2012/13.

Plans to embed this further are being put in place, for example by:

- targeting people who are obese or have other health risk indicators, and designing a referral pathway around them. If they meet certain criteria, GP remuneration is dependent on referring them onwards, for example to an exercise programme or a specialist
- developing a jointly agreed tobacco policy that commits partners to various actions
- cutting the commissioning timescale for public health by more than half, by setting

up a Commissioning Board, agreeing its priorities and employing project management specialists who treat the work of the Board as a project with a monitored project plan

- ensuring staff have received training in project management and on how to work with elected members.

Working with district councils

- The public health team sees it as a priority to work with district councils, given the contribution of their core functions to health.
- The county council's executive member for public health and deputy participate in all ten of the district local strategic partnerships. The council's executive members for adult care and children also have strong relationships. Districts are also represented on the Health and Wellbeing Board.
- District councils are members of the county-wide officer Public Health Board, whose meetings are held around the county, hosted by the district councils.
- District councils helped co-produce the public health strategy.
- There are two district council officers and two district council elected members on the county Health and Wellbeing Board.
- All of the above create forums at which the district councils are encouraged to learn from each other's health strategies.
- The county council continued the NHS public health partnership fund from which each district council received £10,000 in the first year which can be spent on a public health and/or Health and Wellbeing Board priority. This fund will increase significantly in size in the next financial year to fund local programmes.
- A workforce development strategy is in place to provide joint training for district, county and third sector public health roles, funded by the county council.
- The public health team is currently scoping health and housing projects, and has already developed links with the planning, leisure, environment and community safety teams in district councils. A year of cycling is currently being planned between districts and county and a whole system obesity pilot is being developed in one district, led by the district with public health supporting, in Broxbourne.

Future plans

Now that the strategy is agreed the delivery of an implementation plan is expected by March 2013 and the following key priorities are already being worked on for the next two years:

- Obesity Plan
- Physical activity and lifestyle offer
- Tobacco Control Plan
- developing a harm reduction approach to tobacco
- recommissioning sexual health services
- a child health strategy
- integrating childrens centres and health visitors
- enhancing the public health role of partners (commissioning health improvement services from the county council, district councils and third sector agencies)
- older peoples' health
- health improvement in residential care.

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Case study

Royal Borough of Kingston upon Thames: public health, inequalities, migrant communities, community engagement and empowerment

"We are particularly proud of our public health team's successful and expeditious reintegration into council after 39 years in the NHS. Most public health needs are best dealt with in local authorities who are tuned into local people's needs and able to target resources where they can do most good.

Although we have always worked closely with our NHS partners every effort has been made to strengthen this generational opportunity to tackle public health issues at a local level.This has included working hard to protect preventative budgets in order to achieve the most beneficial health and social outcomes locally."

Councillor Liz Green, Council Leader and Chair of the Health and Wellbeing Board

"Kingston is generally a healthy place to live and work, with better life expectancy and healthy life expectancy than the London and England averages.

But local marginalised groups still experience significant disadvantage and far poorer health outcomes than the majority of the population. A major focus of our work is therefore on implementing innovative interventions for excluded communities across Kingston strategic partnerships. We seek to ensure our approach is transformational, proportionate and tailored to addressing need for those who are most disadvantaged."

Russell Styles
Associate Director of Public Health

Key message

- Kingston is using public health evidence based practice to tackle health inequalities and wider determinants of health through innovative community development approaches to partnership, education and empowerment.

Context

The Royal Borough of Kingston upon Thames is a small compact outer London borough. Kingston is an ancient market town and is one of the least populated London boroughs and the seventh smallest in geographical area. A total of 194,163 people were registered with Kingston GPs in 2013, over 33,000 more than the 2011 resident population. It has approximately 25.5 per cent minority ethnic residents, among whom the Asian community is the largest, making up 16.3 per cent of the total. Life expectancy for people in Kingston is 2.2 years more than the England average for men and 1.6 years more for women. Kingston has the fifth lowest life expectancy gap in London.

There is a strong record of partnership between local government, the NHS and the voluntary sector. Improving health and reducing health inequalities is Objective 8 of an overarching Kingston Plan. Prior to April 2012, the Director of Public Health (DPH) had been a joint appointment for six years. As a result, the transition to the council (32

staff transferred, including the DPH and 8 senior staff who make up the Departmental Management Team) has proceeded smoothly with little major upheaval. There is a general feeling that being based in the same complex has made 'horizontal working' between public health and other council departments even easier. The public health function is further embedded within the council through the DPH participating in weekly Senior Leadership Team meetings and senior public health representation on each of the council's four main boards: the Health and Wellbeing Board, the Children and Young People's Board, the Safer Kingston Partnership Board and the Place and Communities Board. The input of public health into important council strategies, including the Housing Strategy has helped to ensure successful and joined-up partnership work, such as with the delivery of fuel poverty interventions.

Kingston's Equality and Community Engagement Team (ECET) is commissioned by the Associate Director of Public Health. The eight-member team's approach is based on the NICE guidance, 'Community Engagement in Health'. The work of the team has developed in response to the JSNA, recent Annual Public Health Reports, and the directing of the Health and Wellbeing Board Strategy. The team adheres to the Marmot principle of 'proportionate universalism' in aiming to ensure that actions to address needs are proportionate to the degree of disadvantage. ECET's work is represented in a number of the council's corporate strategies and plans, including both the Strategic Business Service Plan and Public Health Service Plan.

Refugee and Migrant Strategy

ECET has developed a broad partnership approach to its work with refugee and migrant communities. Its six priorities, agreed with the partners with which it works are:

1. improving health
2. improving housing
3. community safety
4. improving communication
5. improving volunteering opportunities and employment
6. improving information and advice.

The Refugee and Migrant Strategy (RMS) is a good example of how ECET is ensuring that addressing health and wider determinants of health is central to the council's and strategic partners' approach and plans. The needs assessment undertaken as part of the RMS showed that many refugees and asylum seekers in the Royal Borough of Kingston experienced problems accessing health services, such as GP services. This was sometimes due to a lack of understanding how the health system worked, confusion over the specific paper work required or language barriers. The vision for change developed as part of the strategy made a commitment to:

- commission services that support refugees and asylum seekers
- develop clear guidelines for healthcare staff about eligibility and access
- create a culture of "register patients first, then investigate eligibility"
- work with other commissioned healthcare providers to ensure that equal access guidelines are clear and to promote the needs of these communities.

The RMS was reviewed for the inception of the Health and Wellbeing Board (HWB) and in response to the Joint Health and Wellbeing Strategy, one of whose four key priorities is improving the health of disadvantaged communities. The HWB's first major piece of work for disadvantaged communities was to endorse and take on responsibility for developing, implementing and monitoring RMS key performance indicators. Reports on progress are made to the HWB every six

months and decisions are taken on future direction, where necessary. For example, in response to the numbers of refugees and migrants fleeing the warzone in Syria, funding has recently been increased for crisis support of this community.

Further interventions of the Joint Health and Wellbeing Strategy for disadvantaged communities include ECET supporting groups with development and releasing capacity through utilising community development approaches to education and empowerment. A small sample of these initiatives is given below.

Training community health advocates
A public health-funded Community Development and Health course, accredited by the Open College Network, has drawn on expertise from across the council in the teaching of learners. The course recruits health advocates from the most deprived communities in the borough and runs modules such as those on building the strength of communities and power and powerlessness. There are 15 graduates of the course in 2013 – key outcomes include personal qualifications, new learner-led participation in communities, and public health retaining key links to those communities through course members. Graduates have also gone on to further learning and employment opportunities. A recent success has been to appoint a graduate of the Community Development and Health course as a Korean link worker as part of the European Funded 'Empower and Inspire' programme described below.

Empower and Inspire
Kingston's Empower and Inspire programme has won a £240,000 European Union Integration Fund bid. The programme will focus on the positive health outcomes it can bring for community members who are often isolated and vulnerable – particularly women and young people who don't have English as a first language. By improving English language skills, the intention is that the project will give people independence in accessing health and other services, improving their health, becoming integrated with the wider community and helping them to get on in life – all important aspects of their general wellbeing. Empower and Inspire builds on the success of the European Integration Fund programme delivered by ECET between 2009-13. The new programme will involve the council's Heritage Service as part of a project to raise the profile of All Saints Church where the Kings of England were originally crowned. New community facilities will also be provided, which will include English language support for migrants/third party nationals and young people.

Income Maximisation Project
ECET's public health-commissioned work on income maximisation in association with Kingston's Citizen's Advice Bureau (KCAB) was a very early example of work to mitigate the impact of welfare reforms and the recession. ECET set up a number of programmes including financial capability training sessions run by KCAB throughout the borough. The objectives of these sessions were to help develop and empower residents to take control of their own personal financial situation and reduce stress and related wider determinants of health issues.

A number of partners were engaged to advise and refer clients and those that they support to the sessions. The partners include those working in adult social care, the council's benefits department and the income recovery team, children's centres, voluntary organisations who support vulnerable and disadvantaged groups and local community groups. In addition referral flyers and posters advising and giving details of the content of the sessions were distributed and displayed at strategic locations such as GPs' surgeries, community venues, local neighbourhood notice boards and in the council's advice and information centre. Process, output and outcomes indicators were also put in place to measure impact. An evaluation amongst tenant learners who attended the sessions

(with a comparator group of people who had not taken part) indicated positive behaviour changes among participants, including changes in money management resulting in positive financial benefits.

Learn English at Home
Learn English at Home (LEAH) is a voluntary organisation that supports and empowers Kingston residents who have limited spoken English language to attain a level of English needed to communicate their everyday needs and assimilate into the wider community. One-to-one home tuition is provided by trained volunteers, community classes and social activities. ECET set up an innovative project with LEAH which has previously received funding from both external funders such as the Migration Impact Fund as well as Public Health which aims to embed English and health messages into English language provision. More recently LEAH have also set up weekly community 'walk and talk' walks. Sessions focus on specific topic areas each week, doing basic skills activities such as 'cook and eat' while learning English which embed nutrition, exercise and mental wellbeing learning within them. The project Director and ECET have discussed plans to incorporate pre-natal and post-natal key messages including breast feeding, nutrition and emotional support for new mothers who do not have English as a priority, again aiming to give children from marginalised groups the best start.

Future plans

To further develop its work with disadvantaged communities, the ECET Plan is currently being refreshed as a three year plan for 2014-2017. The Plan is being revised under the headings of the 6 Marmot objectives. Interventions that fall under the main Marmot objectives include strategic and community development work to tackle poverty issues, further researching the needs of refugees and asylum seekers and developing localised partnership plans, developing a strategy for prioritised work in geographical locality areas of deprivation and further developing volunteer community advocates who can reach into marginalised and vulnerable groups.

Concurrently, the core data set of the JSNA is also being revised and compiled under the Marmot objectives. This involves public health working across council supported by data specialists in the Kingston Data Observatory. Developing work streams for public health include partnership groups focussed on creating fair employment and good work for all (Marmot Policy Objective C).

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Case study

Lancashire County Council: systematic assets approaches through all council activity

"Lancashire's communities have a wealth of skills, capacity and energy that are already used to keep people healthy. There are already lots of examples of where we are building and using community assets through our services to create healthy communities and increase self-reliance. As a county council we are committed to fairness and have identified the Marmot Review principles as our priorities. We are working with our partners to explore what else we can do to create a climate where the assets of all of our communities can flourish and this is reflected in our Health and Wellbeing Strategy."

County Councillor Azhar Ali
Cabinet Member for Health and Wellbeing

"We know that strong communities and social relationships are one of the most important determinants of health. Being socially isolated is as damaging to health as smoking 15 cigarettes a day. Strengthening and building the assets of our communities is therefore a major public health priority for us in Lancashire. We now are looking at how we can scale up and spread community assets approaches to as many of our public health and prevention services as possible, by developing an integrated wellness system in the county."

Sakthi Karunanithi
Director of Public Health

Key messages

- The transfer of public health is enabling community assets approaches to be systematically embedded across all council functions.
- The strong history of joint work between public health and the council has meant good progress in accelerating health and wellbeing improvements.

Context

Lancashire is an upper-tier council with 12 districts, 6 clinical commissioning groups and a population of around 1.2 million. It covers both rural areas and urban conurbations and includes some of the most affluent and most deprived areas of England. Prior to the transfer of public health the council worked with three PCT public health departments, and around 80 public health staff moved across. Public health sits in the newly formed Adult Services, Health and Wellbeing Directorate.

The council had an existing Joint Health Unit and since 2009 has been working with public health to develop community assets approaches to health and wellbeing. With the transfer of public health this is being extended and systematised. A multi-agency community asset network involving Lancashire Council, local district councils, the voluntary and community sectors, and neighbouring councils Blackpool and Blackburn with Darwen collaborates to embed community assets approaches in everyday practice.

Community assets approaches

Community assets approaches identify the capacity, skills, knowledge, connections and potential in a community and enable people to build on these to make the improvements they themselves have identified as important. The council and the health and wellbeing board have agreed to adopt this way of working as a fundamental shift to how it do business. This is being carried out in two main ways that will, over time, dovetail together:

- within specific initiatives
- through large scale organisational change.

Some examples of initiatives include the following.

Connect4life
In some areas of Lancashire multi-disciplinary case conferences based around GP clusters of around 20,000 people take place. Community connectors from the voluntary and community sector attend these meetings and receive referrals of individuals with medium to high support needs who may benefit from being linked with, and contributing to, their local community.

Healthy streets initiative
This builds on research that suggests that slower traffic can encourage more connected communities. Where 20mph zones are created, community involvement officers from the Environment Directorate work with local communities to map assets and help local people achieve ways of making their lives better, for example tackling dog fouling.

Lancashire time-credits
An initiative run by Spice, the Young Foundation, Lancashire County Council and Chorley Council in which time credits are given in return for voluntary work in local communities. One hour of work earns one time-credit (a locally designed note) which can be spent on local facilities such as leisure services or a theatre visit. The scheme aims to build communities by encouraging people who may not usually get involved in their local area.

Red Rose Recovery/ Lancashire Users Forum
Red Rose Recovery supports people in recovery from addiction and substance misuse by focusing on skills, motivations,

and aspirations and connecting with local resources; it works closely with Lancashire Users Forum which provides a voice for the recovery community and their families.

Many such examples being piloted either across or in different areas of the county. Initiatives are being evaluated and where they prove beneficial and cost effective will be scaled up across the county.

Large-scale change

The council is developing a framework for introducing assets approaches across all its functions; below are the key principles with practical examples of how this would be implemented.

Driver 1 Changing the system
Embedding assets into policy, strategy, and commissioning; for example, clauses in contracts stipulating employment of local people.

Driver 2 Data and intelligence
Incorporating intelligence about local assets into decision making, measuring outcomes and developing an evidence base; for example, consider integrating data and intelligence services across Lancashire into a single hub, responsible for the Joint Strategic Needs Assessment which is developing to use an assets ethos.

Driver 3 Changing the culture
Producing training materials targeting different staff groups, sharing skills, embedding assets into workforce development; for example, job descriptions identify how assets apply to the post.

Driver 4 Enabling communities
Building resilience in communities and trust between communities and institutions to enable sustainable local change; examples include the specific initiatives described above.

Other developments following public health transfer

Health in district councils
As a large council, Lancashire has a range of mechanisms for engaging with elected members at all three levels of local government. Public health consultants are linked to district councils which also have public health staff assigned to work within the district. There are six locality health and wellbeing partnerships in place on clinical commissioning group footprints, which link to the county health and wellbeing board; they have local work programmes relating to the Joint Health and Wellbeing Strategy and including local priorities. Developments taking place since the transfer include:

- major developments in districts are now assessed for their health impact
- housing is a priority, particularly affordable warmth.

For example, each district council delivers affordable warmth measures targeted at people with health problems, and the public health grant is supporting this work.

Alcohol harm
Public health is having a greater role in relation to alcohol harm, through better use of data intelligence and working with the licensing function; for example, a connection was identified between a particular licensed premises and A&E attendances as part of a license review; a number of evidence based measures were implemented by the establishment such as training for bar staff and increasing seating, and hospital attendances linked to the premises reduced.

Implications of the Francis report
Public health is leading on identifying lessons for the council about improving quality standards based on the Francis report on Mid Staffordshire NHS Foundation Trust. Lancashire is also one of the first councils to

join the Advancing Quality Alliance, promoting quality in healthcare.

Future plans

As well as extending community assets approaches system-wide and through every part of the council's business, forthcoming priorities include the following.

- Redesign of public health services to provide a single point of contact model for people who need support to be healthy, covering healthy lifestyle support, and services such as debt. An important element of this will be connecting people who need extra support to be healthy with local community assets.
- Investigate the impact on health and wellbeing of the recession, particularly food and fuel poverty.
- Carry out a programme of work with the Institute of Health Equity (based on the work of the Marmot review) to develop and embed a social determinant approach to health.

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Case study

London Borough of Newham: developing healthy urban planning

"It's absolutely right that public health responsibilities are being returned to local authorities, and we've managed to achieve a considerable amount as a result of partnership working within less than a year of public health coming back into the council.

A local approach means we can integrate our efforts to tackle the wider determinants of health outcomes, from planning, to employment, to enforcement. We're giving planners the tools to get the best deal for residents' health out of new developments. But we're also improving standards in the existing built environment through the country's first borough-wide private rented sector licensing scheme.

I hope that what we've learned on our journey will be informative and challenging for colleagues across local government, and I welcome the opportunity that Public Health England offers to share new ways of working across the country."

Sir Robin Wales, Directly Elected Mayor

Key messages

- A history of joint working between public health and planning ensured health issues were built into planning policies even before public health moved into the local authority.
- The links between public health and planning have meant that, following the transfer of public health to the local authority, public health staff were able more easily to engage with the local government agenda and show the relevance of public health to the local authority's central concerns
- Healthy urban planning is now high on the agenda of councillors and senior management in Newham and a toolkit is being finalised locally to mainstream and embed healthy considerations as part of the planning application process..

Context

The London Borough of Newham is the third most deprived local authority area in England. It has a population of around 308,000 people. The borough has an unusually young age profile compared to the profile for England, with only 6.7 per cent aged over 65, compared to 16.5 per cent nationally. The borough is considerably ethnically diverse, with large populations of Asian and Black African origin, as well as White, and many other people with family origins all over the world.

Whilst life expectancy and death rates from major diseases in Newham are improving (81.1 years for women and 82.6 for men, on average), the gaps between Newham and the London averages remain. Health inequalities are also emerging between different parts of Newham. The gap in life expectancy between the best and worst wards was in 2012, 11.5 years for men and 13.5 years for women. The borough's premature mortality rate is the third worst in London and it has the second worst one year survival rate for cancer in England. Newham has high rates of children living in poverty and of deaths occurring in the first year of life. Newham has the highest tuberculosis rate in England. It also has the highest unemployment rate.

The proportion of homes not meeting the 'decent homes' standard is higher than the London average at 27 per cent. Recent data suggest that Newham has the highest proportion of housing classified as 'overcrowded' in London, at just under 18 per cent.

It is against this context of deprivation, poor housing and overcrowding that Newham's public health team has been working with the council's planning department for some years to promote the idea and the reality of a planning strategy that supports the health of residents.

Relationships with planning

When the borough's local plan was adopted in 2012, there was already a good working relationship between public health and planning policy. A regeneration manager was appointed in 2010, based within the previous Newham PCT, to oversee the health input to a range of projects in the borough, including the regeneration of the Queen Elizabeth II Olympic Park and the redevelopment of Royal Docks. The postholder was part of the Public Health Directorate, working under a jointly appointed Director of Public Health, based for one day a week in the council's planning department.

A number of the priorities in the 2010 JSNA – education and employment, timely access to excellent services/support, crime/fear of crime, and housing – had explicit links with spatial planning policies. Recognition of these links meant that it was possible to incorporate policy SP2 Healthy Neighbourhoods, in the Newham's Core Strategy document, its local spatial development plan. This core policy explicitly refers to how planners will work with health partners to implement it and how it will 'promote healthy lifestyles, reduce health inequalities, and create healthier neighbourhoods'. It puts integration of services up front and builds joined-up working into the planning process. It also makes it a requirement for all major planning applications to submit a Health Impact Assessment or to address its scope as part of their supporting documentation.

On transferring with approximately 16 public health colleagues to the council in April 2013, the regeneration manager has continued to build relationships within the planning department. A smooth transition was possible because of previous well-established joint working practices which continued as before. What is different and more noticeable since the transfer is the importance that senior management and councillors in both public health and the rest of the local authority are giving to the agenda of health and planning, and the new innovative ways that this agenda can be delivered through closer working links with the local authority. The links between the two have meant that the local authority can engage with public health in a key area with which they are familiar and comfortable. At the same time, there is an opportunity for public health to show that it can contribute to a core local authority function.

The Head of Planning and Regeneration, planning policy officers and development control colleagues are supportive of the healthy urban planning agenda. The councillors who lead on health and social care and the councillors with responsibility for planning have also taken a keen interest,

as has the council's executive director. The elected Mayor of the borough whose priorities include planning and regeneration spoke at a conference to launch a Plugging Health into Planning guide in which Newham is featured, at which he emphasised the interconnections between the two.

A number of workshops have been run by the public health team for councillors and officers from planning, social care and health to promote the ideas on how to take the agenda forward locally and how to build further on existing work and partnerships.

Influencing the planning process

The Core Strategy sets out a requirement for developers to undertake a health impact assessment of all major development proposals. This idea is increasingly being taken on board by developers, especially as planners are able to point to health policies in the strategy and to the need for developers to show that their proposals will fulfil health-related criteria. The core policy, SP2 Healthy Neighbourhoods, states that development proposals which respond to the following contributors to health and well-being will be supported:

- the need to promote healthy eating through taking into consideration the cumulative impact of A5 uses (hot food takeaways)
- the need to improve Newham's air quality, reduce exposure to airborne pollutants and secure the implementation of the Air Quality Action Plan, having regard to national and international obligations
- the need to improve employment levels and reduce poverty, whilst attending to the environmental impacts of economic development including community/public safety, noise, vibrations and odour and the legacy of contaminated land
- the need to improve housing quality and reduce crime, insecurity and stress and improve inclusion through better urban design
- the need for new or improved health facilities, and importance of protection and promotion of local access to health and other community facilities and employment, including sources of fresh,
- healthy food in line with Policies SP6 (Successful Town and Local Centres) and INF5 (Town Centre Hierarchy and Network)
- the importance of facilitating and promoting walking and cycling to increase people's activity rates
- the need for new or improved inclusive open space and sports facilities to encourage greater participation in physical activity and provide relief from urban intensity
- the role of Newham University Hospital as a key provider of clinical care and expertise, employment and training provision.

The principles outlined above were informed by an in-depth local evidence base. For example, in preparing the strategy, a food outlet mapping study was carried out. This included identifying areas with poor access to healthy fresh food and areas with an over concentration of unhealthy hot food takeaways, in order to provide an evidence base for commissioning "appropriately targeted interventions to support improved access to healthier eating options for residents". The core strategy incorporates this by encouraging allotments and community food growing projects, by using planning to "protect isolated shops" to ensure that most people are within a five-minute walk of a shop and by promoting diversity of uses within the high street and main commercial areas.

The influence of public health is also evident in masterplanning in the borough. For example, the Stratford Metropolitan Masterplan aims to achieve healthy urban development in the neighbourhoods that are being developed around the Queen Elizabeth II Olympic Park. This includes

creating good access routes into the Park for walking and cycling, maximising use for the whole community of the Olympic sport and leisure infrastructure, maximising access to jobs and employment, providing local people with sustainable, well designed, homes, and promoting the delivery of sustainable communities and neighbourhoods that facilitate the adoption of a healthier lifestyle.

Working with five other London 'growth' boroughs, Newham contributed to developing the London Healthy Urban Planning Checklist. This provides planners with a guide to the main likely implications for health of the proposed development and also provides them with an easy guide to the local policies and standards that apply to each one of the criteria mentioned in the guide. The checklist also provide planners with prompts for questions or for requests for further information to support an application and allows planners to understand and identify where the health-related impacts from development may be, and the extent to which adverse impacts can be mitigated through planning conditions or obligations on development granted planning permission.

Future plans

Newham aims to use the London Health Urban Planning Checklist as a basis for further work and to tailor it to the borough's particular needs, for example in relation to the diversity of the population, employment, sustainable development, lifetime homes and air quality It aims to align the Checklist to local targets and objectives, which may differ from other areas within London and the UK, in other areas of the Council's planning and regeneration strategies.

Further workshops are planned by the public health team to promote and take forward the approach of the checklist. The overall objective is to embed the healthy planning agenda deeply into the culture of the local authority, so that the issues can be raised and prioritised by the whole local authority and embedded within every department,

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Case study

North Lincolnshire Council: integrated public health and strategic public health outcomes fund

"The transfer of public health brings a significant opportunity to improve the health of the residents of North Lincolnshire. The government are quite rightly empowering local councils to pick up on the key challenges which impact on their local population. In our area, as a result of public health being embedded in the council, we have already started to deliver on our ambitious plans to improve our residents' wellbeing through the planning process. This will ensure that planning policies which put the health and wellbeing of North Lincolnshire residents in the front of the planning process. There is a great deal to do, however we will rise to the challenge."

Councillor Rob Waltham
Chair Health and Wellbeing Board, and
Cabinet Member for People Services

"With the transfer of public health to North Lincolnshire Council strong links remain, governed by the core offer MoU and work plan; the noticeable impact has been the recognition, by CCG staff and members, of the need for public health input proactively into strategic discussions and implementation of action plans and advocating for public health interventions."

Allison Cooke, Accountable Officer
North Lincolnshire CCG

"From the outset we wanted to ensure the reach of public health throughout North Lincolnshire Council, embedded in all we do. A Hub and embedded teams supported by the outcomes fund has meant that across the organisation discussions have taken place regarding how all aspects of the council can help achieve the public health outcomes."

Simon Driver, Chief Executive

Key messages

- The transfer to local authorities means it is easier to have discussions about health and wellbeing; it also provides the mechanisms to take plans beyond discussion to completion.
- Sharing public health funding with responsibilities for the public health outcomes framework (PHOF) is a useful way of achieving ownership of health across the council.

Context

North Lincolnshire is a unitary council which includes both rural areas and urban conurbations, with a population of around 167,000 people. Overall, deprivation is lower than the England average, but there are areas of deprivation and health inequalities, with a variation of around ten years in life expectancy between different areas. The population of older people is growing more quickly than the England and Yorkshire and Humber average. Public health worked closely with the council during a shadow transfer phase and around 25 public health staff transferred to the council along with two direct provision teams: breast feeding peer support and health trainers (around 45 in total). Some of the staff who formally transferred were already embedded in the council as part of joint teams.

Integration across the council

One of the aims of the transfer of public health in North Lincolnshire was to distribute benefits, responsibility and risks across the council, with shared ownership of the PHOF. Some of the main ways in which this is being achieved include structure, shared budgets and commissioning.

Structure

North Lincolnshire operates a hub and spoke model with a small, senior public health team at the hub to coordinate and drive public health across the council. This includes the Director of Public Health and three consultants responsible for strategic oversight assurance, partnerships and emergency planning. The consultants each have a lead, but not exclusive, responsibility to each of the three council directorates: People, Places, and Policy and Resources. They attend the senior management teams in each directorate so that public health influences the work of the council at a senior level.

Health improvement teams are located within two of the council's three directorates:

- People Directorate – a health improvement team
- Places Directorate – a health improvement team, a public health intelligence team and a substance misuse team.

These teams are embedded into the most appropriate area of the council with the aim of getting added value and synergy of co-working.

Public health outcomes fund

The council identified £600,000 from the Public Health Grant to invest in council services that would help deliver public health outcomes in 2013-14 and again in 2014-15. As well as shared ownership of outcomes, the aims of this fund are to raise awareness of the importance of health and wellbeing through all levels of the organisation, and to help front-line staff to work with a health improvement perspective.

All directorates were invited to submit proposals for one-off initiatives that would contribute to outcome measures and indicators from the public health outcomes framework. There was a huge response to the process and 19 bids, which sought to tackle a wide range of social determinants of health, were selected by the Directors of Public Health and Policy and Resources. Progress

will be assessed through quarterly monitoring of the PHOF. Successful proposals include:

- extending the Get Going programme to reduce obesity in children and young people aged 6-16 to children aged 4-16
- training suicide prevention advisors and delivering self-harm courses in the community
- targeted swimming classes for specific groups such as looked after children
- transport to multi-sport sessions for people recovering from a stroke
- an independent domestic violence advocate for young victims of domestic abuse
- extending the Walking the Way to Health programme to include half-hour walks from GP surgeries
- funding for the voluntary and community sectors' grants programme.

Commissioning
Public health is working with council commissioning to share learning and improve and integrate within the council's emergent 'one council commissioning' model. An example from the shadow transition period was joint work on re-commissioning sexual health services. The PCT and council agreed that they wanted to move towards a community based model of service delivery. The subsequent process resulted in a more cost effective service based in five localities which started in April 2013. Public health has brought skills around forming evidence and outcomes-based specifications, the local authority around contracting. The contract for childhood weight management has successfully been brought in-house and the council is now considering whether the weight management service for adults could also be delivered internally.

Integration
Public health is integral in the health and wellbeing board's plans for increased integration. It has agreed an Integration Statement setting out the collective ambition to transform services to provide sustainable and integrated care and support, and to develop a 'single organisational model'. The three priority workstreams which all have public health consultant input are:

- conception to age two-years
- young people vulnerable to risk taking behaviours aged 13 to 19 years
- the frail and elderly.

The role of public health and the skills in working across the NHS/council boundary brings an added dimension to strategic thinking and delivery plans.

Other developments following public health transfer

The Public Health Intelligence Team forms part of the Council's research and intelligence function. Key developments include:

- joint work on developing the scope and depth of health and wellbeing data on the council's Data Observatory
- the development of a single council and health and wellbeing board joint strategic needs assessment
- the development of a shared work programme and opportunities for joint work
- across the research and intelligence function
- sharing scarce resources such as specialist GIS, data analysis, statistical and data presentation skills e.g. infographics.

The Cabinet Member for People is keen to increase the profile of health and wellbeing in spatial planning and development. While health is referred to in a range of planning documents there is a danger that it can be lost within numerous other requirements.

A ‘supplementary document to planning’ is being produced which pulls together all health issues for the use of planners and developers.

The Directors of Public Health and Policy and Resources are developing a risk management register which identifies the risks and accountabilities associated with the council’s public health statutory functions.

Future plans

- The council is reviewing the school nursing specification, as well as working closely with NHS England in relation to the health visiting service ahead of it being transferred to local authorities in 2015, to develop both services as parts of an integrated service for 0-19 year olds.
- It will also look at how public health can be more involved in supporting the development of community resilience; for example using health trainers to support more vulnerable people, or developing the role of community health check teams.
- Work is underway to further develop and embed the pilot local ‘start4life’ programme that works with women who are pregnant and have a BMI of 30 plus and their families to support them with exercise and healthy eating. The programme is based within the leisure services department.

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Case study

Staffordshire County Council: connecting with communities, partnerships and assets including business and universities

"As Cabinet Member for Health and Wellbeing, I have seen first-hand the positive impact that bringing public health to the local authority has made. Through integrating the expert skills and experience of existing public health teams with commissioning areas at the county council, we are already seeing improvements in the way services are designed, commissioned and delivered. Ultimately this new way of working is helping to ensure that Staffordshire residents have an environment that supports their health and wellbeing and enables them to make healthier decisions in their day to day lives."

Councillor Robbie Marshall, Portfolio Lead for Safer and Healthier Communities

"The strength of the long-standing relationship between the county council and NHS established long before my joint appointment in 2010 and the later reforms meant that the transition to the local authority was built on effective strategic relationships and commitment to public health. Building on these excellent foundations, the transfer of public health to the county council in April has been a catalyst for further transformation in the county council. Staffordshire has kept itself at the forefront of these national developments, and by embedding public health at the heart of its strategic operating model, the county council has enabled system-wide leadership for health and wellbeing with all partners."

Professor Aliko Ahmed, Director of Public Health

Key messages

- The transfer of public health has enabled the council to enhance its community leadership role for health and wellbeing through forging stronger connections, networks and partnerships across all sectors including business.
- Public Health Staffordshire team has been integrated horizontally, with an outcome focus across the council. It has been operating as a 'team without borders' working across all the council's areas of work.
- The public health team's 'local action: central support' operating principle recognises the vital role of district and borough councils in addressing the wider determinants of health and supports them to take an active role in health improvement at a local level.

Context

Staffordshire County Council covers a population of 845,000 people. The council is primarily rural, interspersed with five major towns and a network of market towns and villages. Staffordshire does not experience concentrated areas of deprivation, although pockets exist in some urban areas. However, the remote rural areas in the county have issues with hidden deprivation, particularly around access to services.

Since 2010, public health and the council have worked closely together; for example, the council's health and wellbeing work programme was aligned with the work of public health in the two PCTs. Around 40 to 45 people transferred into the council in April 2013, and the previous history of joint work meant that public health was able to embed quickly and effectively.

Staffordshire has a complex commissioning landscape: Staffordshire County Council, eight second tier district and borough councils, five CCGs and one Police Authority. Public Health Staffordshire consists of team members drawn from and working within all these partners. The team is integrated across council functions at the upper tier, e.g. in an integrated team including Public Health Intelligence and Customer Insight and at the lower tier, eg secondments and joint appointments in districts. The Director of Public Health is a member of the council's senior leadership team reporting to the CEO.

Vision and outcomes – 'Connected Staffordshire'

The council has been transforming – moving from a service-based approach to become a strategic commissioning council whose work is based on improving outcomes and building on assets. It has established three overarching outcomes – people in Staffordshire should be able to:

- access more good jobs and feel the benefits of economic growth
- be healthier and more independent
- feel safer, happier and more supported in and by their community.

Public health has been a catalyst in the transformation to 'Connected Staffordshire', helping to establish stronger 'connectivity' in corporate thinking. The three outcomes are interdependent, and public health operates across all of them, either in a direct leadership role or by influencing others to promote health and wellbeing (e.g. links with business described below). The outcomes underpin the operating principles used to transfer and embed public health:

- 'local action:central support' – enhancing the district role in the delivery of health and wellbeing outcomes
- asset-based approaches – recognising the assets and connecting across business, community, district and academic partnerships
- mainstreaming health and wellbeing into corporate practice e.g. health impact assessment integrated into all county council policies, plans and cabinet decision making, and public health approaches embedded in the commissioning excellence operating model.

Public Health Staffordshire Principle – 'local action:central support'

The 'local action:central support' operating model is based on acknowledging the important role of district and borough councils in addressing the wider determinants of health and wellbeing. The eight lower-tier councils have been very keen to take an active role in achieving public health outcomes, supported by the county council.

In producing its Joint Strategic Needs Assessment (JSNA) Staffordshire moved from a statistic-based county JSNA to Enhanced Asset-based Joint Strategic Needs Assessments produced by the eight councils with CCGs and other local partners. These build on the knowledge, insights, skills and assets of local areas to establish local priorities which have been included in local work programmes overseen by local health and wellbeing groups/boards. Districts have match-funded public health development officer posts with the county council; officers are based in local offices with a remit to

deliver on the work programme and influence action on the wider determinants of health. Some examples of work so far include the following.

Health and housing
Public Health Staffordshire has been working with the Housing Department in Tamworth on a 'Healthier Housing Strategy'. Actions include a focal approach on winter warmth interventions, such as identifying vulnerable people who would benefit from immunisation and from improvements to their housing. This initiative has contributed to a significant improvement in rates of excess winter deaths, with Tamworth now having one of the lowest rates in England.

Community food programmes
Public health and the districts are working together on a sustainable approach to prevent the cycle of food poverty, based on priorities identified through the JSNA and insight from local community leaders who report poor food budgeting and lack of cooking skills in disadvantaged areas. This involves devolving county funding to localities where it is match-funded by districts/partners. Capacity building is taking place though districts and local voluntary and community sectors.

An asset-based approach with Staffordshire businesses
The council recognises the vital role that the business sector has in improving and connecting the economy with health and wellbeing in local communities. Public health has developed networks with large and smaller local businesses and is encouraging the adoption of the Staffordshire Workplace Health Framework, which supports businesses to take action on:

- sickness absence management
- workforce, family and community health and wellbeing
- supporting vulnerable people and carers in employment
- the interdependence of mental health and employment and the growing impact of unpaid care demands on the working age population
- an incentivisation scheme, with specific standards and criteria, which enables businesses to demonstrate their commitment, improvements and outcomes
- Corporate Social Responsibility (environmental awareness, business community development and mentoring, third sector engagement and staff placements, and wider community development work).

Corporate Social Responsibility (CSR) involves two important assets – business and the voluntary and community sectors working with each other and collaborating to achieve positive social and economic outcomes. Examples include business mentoring schemes, voluntary work placements, community sports events and a mental health and wellbeing training programme delivered by the voluntary sector with businesses.

Public Health Staffordshire is currently working with one of county's largest employers – Alstom, who are working through the framework, particularly focusing on areas around sickness absence management and workplace mental health. The Public Health Intelligence team are also supporting Alstom to develop monitoring systems that will measure the impact of their CSR activity, enabling them to demonstrate the benefits and further mobilise valuable resources in the community.

An asset-based approach with Staffordshire community and voluntary sector
Previously, commissioning from the community and voluntary sector was largely based on grant-giving and historical patterns. The transfer of public health to the council allowed for the development and implementation of a more connected and effective approach to commissioning based on outcomes and assets.

Public health and the sector co-produced and piloted the Staffordshire Public Health Commissioning Prospectus which facilitates outcome-based investment. This involved working together on commissioning processes, timescales, documentation, health and wellbeing outcomes, performance measurements, and showing transparency.

The pilot was independently evaluated by the Young Foundation which concluded that overall it was an effective approach which could demonstrate improved outcomes. As a result, the prospectus approach has been mainstreamed and now forms the basis for future public health commissioning.

An asset based approach with universities
The university sector is seen as a major asset for improving health and wellbeing through research, evidence and technology. The transfer has facilitated a stronger relationship with the sector, focussed on strategic priority areas rather than individual research projects. This broader approach used health inequalities and social exclusion as the platform to bring key partners together to establish the Centre for Research and Action on Health Inequalities' (CRAHI) – a partnership between Staffordshire County Council, Stoke on Trent City Council and the two local Universities to integrate research and evidence-based practice and to translate this into action to reduce health inequalities.

CRAHI involves the following elements:

- address the gap between academic researchers and health and social care practitioners
- research into factors that contribute to and combat health inequalities
- research into action– translate research and evidence into practice
- best practice – share learning between member organisations on health inequalities and explore collaborations and networks with a wider range of research and action organisations
- central hub for the application, co-ordination, and delivery of research funding applications and programmes
- training and development – develop and deliver a high quality training programme targeted at researchers, practitioners and the local community, such as community peer-led researchers.

Future plans

Developing integration will be a key priority for Staffordshire, and public health is already involved in a range of integration initiatives: eg joint leadership of an early intervention team to reduce the demand for more intensive health and care. Future plans include the following.

- integrating public health resources for children and young people into wider integrated and pooled commissioning approaches to enable primary, secondary and tertiary prevention across child health and wellbeing
- integrated commissioning across key themes, services and geographies, including devolving resources to locality level partnerships and local pooled budgets
- 'One Council' approach – mainstreaming and integrating resources into one Commissioning Prospectus
- integrating workplace health into core commissioning for carers.

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Case study

West Sussex County Council: a DPH with a strong corporate commissioning role

"Bringing back public health to the local authority has been an incredibly positive experience for West Sussex County Council. The appointment of the director of public health to a wider commissioning role across health and social care has built on strong foundations in order to continue to successfully take forward the work of the council as a commissioning organisation."

Kieran Stigant,
Chief Executive, West Sussex County Council

"We are already seeing the benefits of Public Health being part of West Sussex County Council in terms of focusing our work on prevention and providing people with the tools and resources to improve their health and wellbeing. It has never been more important to work in partnership across the health and social care economy and public health being part of the council has helped to drive this exciting work forward."

Louise Goldsmith,
Leader of the Council

Key messages

- Giving additional responsibilities to the director of public health has highlighted synergies with other council functions.
- Drawing on public health skills across the board has added new resources to the local authority.

Context

The population of West Sussex is approximately 810,000. The health of the population is generally better and life expectancy is longer than the England average. Deprivation is lower than average, although about 19,300 children live in poverty, mainly in the towns along the coastal strip and in Crawley. Life expectancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas than in the least deprived of the county. Early death rates from cancer, health disease and stroke have fallen and are better than the England average. Levels of obesity, teenage pregnancy, alcohol-specific hospital stays, breast feeding and smoking in pregnancy and adult physical activity are all better than the England average. However, GCSE attainment, the rate of road injuries and deaths and incidence of malignant melanoma are worse than average. Twenty-one per cent of the increasingly older population are aged 65 years or over compared with 17 per cent in England. The biggest challenge to the council is an aging population.

The expanded role of the DPH

Before the transfer of public health to local government, the director of public health in West Sussex had been working closely with the local authority, West Sussex County Council, and already had some responsibilities for safeguarding and research in the council. This background provided invaluable experience and knowledge in supporting the transfer of around 40 public health staff. Following the transfer, the local authority took the view that it now had a new pool of talent and experience and that, in the context of budget cuts, it should make the best possible use of this new pool. The council made a decision to expand the role of the director of public health to include responsibility for commissioning health and social care services for residents, her new title being Director Public Health, Commissioner for Health and Social Care. This means that she now has responsibility for:

- public health services
- commissioning all adult social care and related wellbeing services
- children's social care and related services (eg children and family services, but not learning, which comes under Education)
- joint commissioning of mental health, learning disability and other services, including drug and alcohol services
- telecare
- safeguarding and domestic violence services
- continuing healthcare
- and is the lead officer for the Health and Wellbeing Board.

The local authority is on a journey to become a 'commissioning organisation'. Therefore, alongside the role of the director of public health as 'commissioner for people', there is also a 'commissioner for place' and a 'commissioner for resources' on the corporate management team.

There is agreement among leading councillors and senior management in the council that this wide-ranging corporate role should be part of developing the council into a fully evidence-based organisation.

Working at the heart of the council

The director of public health is working right at the heart of the council's policy agenda, taking a central role in helping the council review the outcomes it is seeking for the people of the area and the measures and indicators it will use to evaluate its success in achieving those outcomes. The new expanded role has also provided the director of public health with the opportunity to work closely with the leader and cabinet. A good relationship has been developed with the portfolio holder for public health, who has a key role at cabinet meetings, making links across the social determinants of health and intervening to propose ways of joining up services for a potentially greater health impact.

Drawing on public health strengths

The director of public health's new role has also enabled her to bring public health staff into areas which might not traditionally have been seen as part of their remit. For example, some of the public health team are working on issues around building stronger communities and community resilience, economic development and supporting capacity development in the voluntary sector. The technical skills of the public health team, such as modelling, are highly valued by the rest of the council, assisting it to estimate longer term and population-wide health effects of interventions, integrate evidence

from different domains, consider hypothetical 'what if' scenarios, and address issues of cost and cost-effectiveness.

One of the challenges has been to align the public health team with the rest of the local authority. This alignment is on-going with an expanded senior management team across public health and health and social care commissioning.

Another challenge has been to integrate public health work with existing work within the council. For example, a public health team member is now working on drug and alcohol issues, using public health skills such as analysis and clinical understanding of the impact of drug and alcohol misuse and appropriate support and treatment. This provides an opportunity to demonstrate to colleagues within the council and councillors how clinical knowledge can bring added value.

A similar opportunity has arisen in relation to commissioning clinical services and managing contracts, for example in relation to detoxification programmes, in-patient services, prescribing and dispensing services in the community, where clinical skills are needed to specify the right contracts and oversee their implementation. Public health has brought clinical governance into the commissioning of services by the council.

Clinical and other public health skills are also now being drawn on in adult and children's social care and in developing work on community wellbeing. This work and the work described above has enabled both council colleagues and cabinet portfolio holders to gain a greater understanding of where public health skills can be useful to the council, not just within the strict remit of public health, but also in relation to other council functions.

Working with district councils and Clinical Commissioning Groups (CCGs)

While in the NHS, public health teams worked with district councils and the CCGs. In the council, that relationship has both changed and developed with public health taking on more locality working. In addition, district councils have been commissioned by the public health team to carry out the traditional health promotion role in their areas. This means that the districts themselves are now commissioning some public health services, such as those relating to reducing obesity.

This year, the DPH's annual report is focused on health and housing, which also involves working closely with the district councils, taking a lifecourse approach to housing and homelessness; and addressing the impact of the large, poor quality private rented sector and lack of social housing in the county. The public health report considers the need to:

- improve carers' access to housing both in terms of affordable housing, and the risk of carers being made homeless (due to sale of properties to fund residential care)
- work with private landlords to improve the condition of private accom-modation offered in West Sussex
- review how housing support for older people is funded and services delivered
- monitor the impact of the recession and changes in benefits on people's access to suitable accommodation
- provide accessible housing advice and support for carers such as financial and welfare benefit advice; information on adaptations and home improvements to enable carers and their families to 'stay put' in their home.

Future plans

The public health team has worked with stakeholders to develop priorities for a five-year (2012 to 2017) public health plan 'Healthy and Well in West Sussex' which outlines the needs, challenges and commitment to action in a number of different areas related to the Marmot priority policy areas. There is an emphasis on support for carers, as this is seen as a particular issue among the ageing population; and on the influences on health of housing, employment, education and alcohol, all areas in which the county faces increasing challenges.

Some areas of the five-year plan are more developed than others and for some issues the council will be working initially to understand more about them and their impact on residents' health.

Alongside the public health five-year plan, a partnership plan for action on health inequalities covering the same period has been developed and agreed with all seven district councils. Three areas have been identified for action to reduce health inequalities:

- tackling area-based urban deprivation
- finding solutions to rural poverty and isolation
- meeting the needs of vulnerable groups.

Individual high-level actions for organisations and partnerships have been agreed to address these issues. The implementation of key actions will be tracked by the West Sussex Inequalities Network, which reports to the West Sussex Health and Wellbeing Board.

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Case study

York City Council: additional roles and extended influence

"We need to consider how each and every public health function and service should be delivered in a council setting and think about what difference it makes, now that they are commissioned by the local authority and not by the NHS. If it ends up making no difference at all and there are no significant benefits realised for residents then we will have completely wasted that once in a lifetime opportunity given to us by the transfer to local authorities in April 2013."

Councillor Tracey Simpson-Laing, Deputy Leader and Executive Member for Health, Housing and Social Care and Chair of City of York Health and Wellbeing Board

"The transfer of responsibility for public health has provided a once in a lifetime opportunity for public health to demonstrate its leadership in building on the rich social reform heritage within the City of York and to begin to significantly improve the stark health inequalities faced by a significant number of residents by directly tackling poverty and the other wider determinants of health. We must demonstrate a level of public health leadership that John Snow, one of the founding fathers and pioneers of public health who was born in the City of York 200 years ago, would be proud of."

Paul Edmondson-Jones, Deputy Chief Executive and Director of Public Health and Adult Social Services

Key messages

Combining the roles of director of public health, director of adult social services and deputy chief executive is seen as having great potential for:

- putting public health at the heart of all council activities and beyond
- ensuring that preventing poor health and loss of independence is fundamental to health and adult social care.

Context

York is a unitary authority with a population of around 200,000. Overall, this is an affluent area with an unemployment rate of just 1.7 per cent. However, there are areas of deprivation and poverty scattered around the city which are often not immediately obvious. The greatest problem is "in work poverty" which is often related to the relatively high cost of housing and high cost of living in the city.

York has a long history of individuals and organisations committed to philanthropy and social justice. It has a well-established voluntary and community sector and a tradition of council service provision. York's challenge for the coming years is to harness these assets to shift the emphasis from providing services to empowering individuals and communities to develop resilience and capacity for independence and self-help.

Combining roles

Prior to the transfer of public health there had been limited joint working across the council and PCT. The current director of public health was the first joint appointment; previously the emphasis had been on healthcare public health and health protection rather than health improvement. A team of only five people transferred to the local authority from the PCT, and these were brought together with the council's existing drug and alcohol action team and sports and leisure team to form the new Public Health Team on 1 April 2013.

In July 2013 the council separated the functions of children's services and adult social care and the director of public health also became director of adult social services. He was subsequently appointed deputy chief executive in August 2013 with a role to support and deputise for the chief executive and to help wider organisational development.

Combining roles has meant that public health is at the centre of the council, with extensive opportunities to bring a public health perspective across all functions and to the work of front-line staff. Also, the council, the clinical commissioning group (CCG), the citizen's advice bureau and other partners have recently co-located to the same building which brings great potential for close relationships and provides a one stop shop with a wide range of services for local people, eg linking vulnerable families with debt-advice.

Arrangements have only been fully in place for a few months, and York is at an early stage in the process of reform.

Partnerships for change

The director of public health / director of adult social services (DPH/DASS) is lead officer for the Health and Wellbeing Board, and health overview and scrutiny, and also represents the council on the CCG governing body.

This presents considerable opportunities in terms of levering change and influence. It will allow public health methodology such as understanding population needs and working to an evidence-base to become embedded in how the council and local partners work. A recent example of joint work is the 'Stop (smoking) before your Op' campaign with the CCG.

Working to Joint Health and Wellbeing Strategy priorities, York Health and Wellbeing Board has agreed a series of commitments for future joint work; these include the following:

- Adopting the national carers charter and the disabled children's charter as a basis for future improvements to information, advice, support and involvement of carers.
- Adopted the national Mental Health Challenge for local authorities which involves ten pledges including mental health champions, a lead officer for mental health in the local authority, reducing mental health inequalities, and encouraging positive mental health. Specific actions are being discussed at the board's next development meeting.
- Adopted the national Local Government Declaration on Tobacco which involves a number of pledges – this ensures that all partners are bound-in and committed and not just the local authority (information available).

In addition:

- York is seeking to become a Dementia Friendly City; for example, a film created with the Joseph Rowntree Foundation and others is being shown in local schools (information available)
- the council has adopted the local government declaration on tobacco and was the first in Yorkshire and Humber to do so
- the council is establishing a domestic violence strategy and seeking to obtain White Ribbon status by May 2014 (commitment to tackling violence against women).

The DPH/DASS chairs the Integrated Transformation Board overseeing the current health and social care integration. Public health is seen as being able to be the 'gatekeeper at the front door' to adult social care and health with a focus on prevention and early identification; this includes physical activity to reduce obesity and reduce falls as well as risk-identification and prevention of vascular disease. It is hoped that a different focus and better targeting of the whole public health budget can lead to increased real savings in health and social care: an initial target has been set by the director of public health that this needs to yield cashable savings to the social care budget of around £1 million a year by better diagnosis, prevention and early intervention.

Another recent development has been York Cabinet's decision to establish a health and social care hub. This collaboration between the council, NHS and voluntary and community sector will involve a city-centre venue for a range of organisations and services aimed at supporting people with low to moderate needs to avoid more extensive services. The hub will be a very important element of the overall Integrated Transformation Fund and Plan and Adult Social Care Transformation programme.

Tackling poverty and inequalities

The Archbishop of York commissioned a Fairness Commission in 2010 which sat through 2011 and reported in 2012. The Commission found that while York was outwardly affluent there were pockets of deprivation and poverty which were often hidden. It made a range of recommendations for tackling this and the council and partners have adopted a York-wide strategy to drive poverty from York supported by information from the Joint Strategic Needs Assessment. This has proved an excellent opportunity to address the economic and social determinants of health, and York public health is fully involved in the strategy. The four key themes of the Anti- Poverty programme are as follows.

- Reduce stigma – the local media has been running a year-long campaign aimed at raising awareness of poverty and tackling negative images.
- Reduce the cost of living – this includes promoting uptake of free schools meals, better availability of white goods, cheaper energy deals.
- Promote a living wage – York council has agreed to pay all its workers a living wage of at least £7.45 an hour and the council is now an Accredited Living Wage Organisation; a requirement of this was that a living wage is part of York's procurement system. Other partners in the city, including Joseph Rowntree Foundation, CVS and St John University have already adopted the living wage and it is hoped that other partners will also do so.
- Tackle destitution – the council supports local food banks and is working with local churches and others to provide crisis loans and support those in trouble.
- Future priorities are measures to tackle:
- the cost of child care which can be prohibitively expensive for people in work
- the high cost of renting houses.

Public health as everyone's business

With a small public health team, influencing others to take an active role is vital. The council is adopting the concept of "Making Every Contact Count" and is looking for opportunities to use the contacts made by front-line staff to promote public health. Public Health Champions are being identified across the council, particularly in functions that have contact with people who may benefit from healthy living advice, such as

housing and education. So far there has been a very positive reaction, described as 'pushing at an open door'.

A number of people have been seconded or transferred to the public health team. These include:

- a member of the communications team supporting activity around social marketing and media awareness
- a member of the wider children and education team to lead on the children's public health agenda
- a member of the policy and strategy team to support the work of the Health and Wellbeing Board.

Future plans

The director of public health describes the full integration of public health into the City of York Council as being a five-year journey in which health improvement is stitched into all levels and parts of the council. Public health will be considered in all council policies and strategies, and all relevant functions, services and individuals will make a contribution to health and wellbeing.

Specific developments underway include:

- considering the future role of school nursing, health visiting and other children's services in a holistic child-centred service that maybe is available 12 months in a year and works from different settings
- considering the future role of tobacco control and the wider prevention, treatment and enforcement issues around nicotine addiction rather than simply smoking cessation.

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