improvement and development agency

The social determinants of health and the role of local government

introduced and edited
by Fiona Campbell

part of the LGA group

Disclaimer

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Dr Campbell is a consultant on public sector policy and governance and an Associate at the Local Government Centre, University of Warwick

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contents

Foreword

In 2008, I was asked by the Secretary of State for Health to chair an independent review to propose the most effective strategies for reducing health inequalities in England from 2010.

In undertaking this review, we are identifying evidence and making recommendations in the key policy areas – the social determinants of health - where action is likely to be most effective in reducing health inequalities. These are:

- early child development and education
- employment arrangements and working conditions
- social protection
- the built environment
- sustainable development
- economic analysis
- delivery systems and mechanisms
- priority public health conditions
- social inclusion and social mobility.

In every single one of these areas, local government has a significant role to play in working with the NHS and other partners in improving health. The biggest area of local government spending is on education and early years. Local authorities can not only improve and protect working conditions through their environmental health role; they can also contribute to the economic development of their areas and, in almost every area of the country, are themselves among the largest employers. In collaborative working with other key players, they can develop and implement strategies towards the sustainable development of the communities they serve. They can be part of the safety net that protects and supports people who need benefits and social services.

Through their planning powers, management of traffic, parks and open spaces, leisure and cultural services, they can contribute to the quality of the built and social environment. They have specific duties and powers to promote equality and social inclusion and social, economic and environmental well-being. They work in partnership with the NHS and other agencies such as the police to support public health. In short, they make a very important contribution to weaving the social fabric of their areas and seeking to create and sustain healthy places for people to be born, grow, live, work and age.

No review of health inequalities and measures to reduce them in this country can afford to ignore the role of local government. I hope, therefore, that this timely publication will encourage elected members and council officers to reflect on their role in reducing health inequalities and creating the conditions for people to lead flourishing lives and to contribute to the review. I hope also that it will act as a catalyst for others both in the NHS and in government concerned with health, to explore the enormous potential in working alongside local government in tackling what I and others have called ‘the causes of the causes’ of health inequalities.

Professor Sir Michael Marmot
Chair of the World Health Organisation Commission on Social Determinants of Health
Chair of the Strategic Review of Health Inequalities in England post-2010

Editor's introduction

"This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."

(WHO Director-General Dr Margaret Chan, at the launch of the final report of the Commission on the Social Determinants of Health).

The social determinants of health have been defined as: "the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment."

(Raphael, 2004)

The publication in 2008 of the World Health Organisation (WHO) Global Commission on the Social Determinants of Health report and the subsequent commissioning by the Secretary of State for Health of the Review of Health Inequalities Post-2010 in England (the Marmot Review) has raised the profile of the social determinants of health and of the importance of addressing the conditions of everyday life that lead to health inequities. The WHO Commission argues that for reasons of social justice, action to achieve health equity is imperative. It says that attempts to reduce health inequity must be predicated on addressing the wider social and economic determinants, such as levels of education, economic status, and power relations. In order to address health inequalities it is necessary to address inequities in the way society is organised.

"This requires a strong public sector that is committed, capable and adequately financed. … In a globalised world, the need for governance dedicated to equity applies equally from the community level to the global institutions."

(World Health Organisation 2008)

The diagram below shows the widening circles of influence on people's health. These circles are, of course, interpenetrable. For example, your lifestyle 'choices' are influenced, even to a large extent constrained by the social, economic and environmental conditions in which you live, as the quotations from Chan and Raphael acknowledge above. Even the difference made by your gender or your age or hereditary factors relating to your ethnic origin will be influenced by the kind of society or community you live in – how it treats older people and women, whether it understands and responds to the health needs of people whose ethnic group is in a minority in that society, and so on. And, of course, people, individually and collectively, influence the circles by the personal and political action they take and the choices they make.

To anyone who knows even a little about the work of local government, it will be clear that local government must be part of the 'strong public sector' invoked by the WHO Commission. The actions of local authorities have an influence, sometimes big, sometimes small, in every one of the circles illustrated below and therefore on the health of their residents. The lower half of the diagram shows only some of the local government activities that impact on the social determinants of health in each one of the circles of influence. Some services, of course, such as the planning function, have an influence in more than one circle – in this case potentially impacting on biodiversity, the 'liveability' of the environment and opportunities for physical activity and recreation. Local government can also make an impact on what the WHO calls the "unfair and avoidable differences in health status" – the inequities in health – between individuals, groups and communities.

In recognition of the role of local government in health improvement and in tackling the kind of inequities referred to by Marmot, the Department of Health has funded the Improvement and Development Agency (IDeA) to develop a Healthy Communities programme of work which aims to:

- raise awareness among local government elected members and officers of health inequalities and the social determinants of health and of the role of local government and its key partners in addressing these
- build capacity, capability and confidence in local government to address the social determinants of health
- ensure local government across England is aware of the Marmot review into health inequalities and the social determinants of health and is able to contribute effectively to consultation
- disseminate knowledge and learning to all local authorities and their partners.


The social determinants of health and well-being
Global Ecosystem
Natural Environment
Built Environment
Activities
Local Economy
Community
Lifestyle
People
age, sex
hereditary factors
libraries
leisure centres
social services
sheltered housing
licensing pubs and clubs
sports development
social cohesion
area committees
community centres
youth groups
community development
Parish plans
neighbourhood wardens
local government jobs
commissioning services
regeneration
trading standards
economic development
business grants
consumer advice
tourism
marketing
day centres
strategic housing
training schemes
benefits advice
bus passes
health and safety
adult community learning
schools
extended schools
physical activity promotion
play provision
car-parking
building control
environmental health
highways management
speed limits
street lighting
play spaces
cycle routes
Pedestrian zones
play streets
CCTV
parks and playing fields
air quality monitoring
parks, cemeteries and open spaces
conservation areas
biodiversity
sustainable development
county farms
allotments
conservation officers
arboriculture
grants for solar panels
waste disposal
recycling
home insulation
planning and development control
climate change strategies
How local government can make a difference

This publication is part of that programme. Its purpose is to provide an introduction to and an exploration of health and health inequalities in England and a consideration, through the views of different writers, of the role of local government in addressing health inequalities through action on the social determinants of health. It is illustrated with practical examples and directs readers to sources of further information and support. Many of the case studies that illustrate the text can be found on the Healthy Communities website of the IdeA.

The publication takes the form of a collection of articles by distinguished practitioners of public health, academics with research interests in the social determinants of health and health inequities and local government professionals. Some of the articles are deliberately challenging and provocative; some of them present a picture of what is already happening in local government to tackle the social determinants of health; some of them look to what more local authorities could do in the future, either with additional powers or by using their existing powers and remit. The aim of the publication is to reach beyond those elected members and officers of local government with a specific health remit and to engage with a broad cross section of local government, primary care trusts (PCTs) and the partners who make up local strategic partnerships (LSPs). It will be the forerunner to a short series of pamphlets which look more specifically at aspects of, and professions within local government and their role in addressing health inequalities.

The articles in the first section explore some of the issues with which local government needs to grapple if it wants to make a positive impact on the health of the citizens it represents and on reducing inequalities in health between different communities of identity and place:

- Professor David Hunter gives an overview of the social determinants of health and the potential role of local government
- Professor Danny Dorling takes apart the much-discussed concept of 'place', looking at it with a geographer's eye, and discusses what it would really mean for local authorities to be the 'place-shapers' they aspire to be
- Mike Kelly and Tessa Moore look at sources of evidence to which local government can turn in devising effective interventions and emphasise the importance of local authorities collecting and evaluating their own evidence
- Professor Alan Maryon-Davis looks at the developing roles of directors of public health and other public health professionals as they come almost full circle to take their place at the heart of local government.

Section 2 considers the strategic and operational implications for local authorities on the ground of the issues discussed in Section 1.

- John Nawrockyi discusses a pioneering course in Greenwich which takes literally the mantra that 'health is everyone's business' in the local authority
- Dr Tony Hill describes his experience of seconding the whole public health team from the PCT to the local authority
- Martin Seymour looks at practical implications of the 'Total Place' programme for health, in bringing together all the resources for an area
- The final chapter in this section briefly discusses individual local government service areas and their potential impact on health and health inequalities. (These service areas will be among the subjects of a forthcoming series of publications from the IDeA.)

In Section 3, a number of different, but not necessarily incompatible approaches to the work of local government are considered in relation to their potential role as tools for health.

- In the most radical and challenging chapter, Professor John Ashton asks us to re-imagine traditional approaches to community development, based on experience in the USA which has influenced President Barack Obama.
- Clive Blair-Stevens explores how marketing approaches initially devised in the commercial world can be harnessed by local government and its public sector partners to meet health objectives.
- Charles Loft discusses some of the new and imaginative ways in which local authorities are using their enforcement roles in licensing, trading standards and environmental health as tools for health improvement.
- Adrian Davis describes the important and increasing use of health impact assessment as a means both of raising awareness of health issues and of evaluating interventions for their effects on health.
- Su Turner considers the increasingly creative ways in which local authority health overview and scrutiny committees are carrying out their work.
- Finally, there is a reminder that local government is in a position to have a direct impact on citizens' health through its role as a major employer across the country.

The context for local government

At the beginning of the Labour Government's administration in 1997, a shared priority was agreed between central and local government on the need to reduce health inequalities. This priority has been maintained throughout political changes in the control of local authorities and their representative bodies. All the major political parties now recognise the need to tackle health inequalities and the role of local government in doing so. The specific mandate for local government involvement in addressing the social determinants of health has come through various policy documents, including successive public health and local government white papers and the strategy document 'Tackling Health Inequalities: A Programme for Action' and associated reports, culminating in the commissioning of the Marmot Review to look beyond 2010.

At the same time, a number of reviews of health services, including that of Wanless (2002) and more recently, Lord Darzi's (2008) review of the NHS, reported in *High Quality Care for All* have supported a shift in effort and focus towards prevention of ill health. Similarly, there has been an increased emphasis in policy on social care and support on taking action to prevent people needing services. This policy focus provides opportunities for local authorities and the NHS to work together to tackle the 'upstream' causes of wider social, economic and environmental determinants of ill health and inequalities.

The concept of local government as a 'place shaper' was developed by Sir Michael Lyons in his influential report, *Place-shaping: a shared ambition for the future of local government*. Lyons defines place shaping as "the creative use of powers and influence to promote the general well-being of a community and its citizens" (Lyons 2007, p.60). He says that local authorities must use their ability to bring together local stakeholders and develop a vision for their area. From the perspective of addressing health inequalities, it can be seen how galvanising this concept of the local authority as place shaper could be. As Professor Hunter in Chapter 1 puts it, health inequalities bring together a number of complex and intractable issues which demand new approaches in respect of tackling them. Their complexity requires the involvement of many partners, working together to attack the issues on many fronts. And this kind of partnership at the local level requires the kind of vision and leadership that local authorities can provide as place shapers.

Partnerships of various forms and at many levels between the NHS, local government and the voluntary sector are now the norm. Every overarching LSP now has a sub-partnership with a remit for the health and well-being of the area – although, of course, because of the nature of the wider determinants of health, *all* of the local partnership bodies have a role to play in health improvement. Over 80 per cent of directors of public health (DsPH) are jointly appointed between PCTs and local authorities. PCTs and local authorities work together on the Joint Strategic Needs Assessments for their areas on which short and long-term objectives for health improvement and well-being should be based. In every local authority area, there are numerous work programmes and individual projects that involve both health, local authority and voluntary sector staff working together, often working out of the same offices.

In recent years, there has been an increasing focus on the collection of evidence to inform interventions that are intended to improve health outcomes, as well as those that have a different primary purpose but which are likely to have a health impact. Local authorities, regional public health observatories, the public health directorates of PCTs and university research departments have begun to work together to collect evidence and evaluate interventions.

Individual health profiles for each area of the country have been developed which give local authorities information about the health of their own residents. They also provide a 'benchmark' from areas with similar levels of deprivation or affluence to their own, against which they can judge progress in their own area towards reducing inequalities **between** geographical areas of the kind discussed by Professor Dorling in Chapter 2. There is also more data available about health inequalities between different groups, such as men and women, older and younger people, people from different ethnic groups, which enables local authorities to look **within** their own areas to interventions targeted at improving the health of groups most in need and thereby reducing inequalities.

As bodies with specific responsibilities to promote equality and social cohesion and as elected representatives of often hugely diverse communities, local authorities have begun (recently with the support of research led by the regional public health observatories) to understand more about how diversity within their communities relates to health. There is greater disaggregation of data accompanied by increased understanding of the correlation between different factors such as poverty, housing, education and environment and health, including the fact that black and minority ethnic groups, especially those of Pakistani and Bangladeshi origin (being among the most deprived) have the worst health and the lowest life expectancy.

Effective and appropriate use of information is one of the themes of this publication. Dorling believes that we already

have enough information to indicate some very clear areas in which local authorities could be making inroads in reducing health inequalities – measures to reduce traffic accidents being one example. At the same time, he points to the importance for local authorities for developing a greater understanding of the role that geography plays in inequality.

Paradoxically, despite interest in the place-shaping role of local government following the Lyons report, there has also been increased emphasis in addressing interventions to individuals rather than to places. This is partly because of evidence that addressing public health interventions to a whole population can increase inequalities. For example, people from social class v respond less to anti-smoking campaigns than those from social class 1, with the result that such a campaign can lead to greater inequality (albeit in the context of a reduction in overall smoking levels). Interventions carefully targeted at individuals hope to avoid increasing inequality in this way.

Dorling's article is a persuasive argument to local authorities to complement approaches targeted at individual behaviour with a response that also recognises the geographical basis of inequality – an acknowledgement of the interdependence of places and people. This interdependence was referred to by the Prime Minister in his announcement of the Marmot Review for England. Gordon Brown pointed out that that *"Life expectancy here in London falls by one year for every underground station you stop at from Westminster to Canning Town" and described this as "the geography of inequality, the geography of injustice"*. This emphasis chimes very well with the place-shaping model for local government.

Dorling also points to the importance of using the right geographical units to develop the kind of revelatory maps for which his work is known. And this will no doubt become an increasingly important issue as more attention is given to developing a robust evidence base for health interventions. The importance of evidence and evaluation is the topic of the article by Mike Kelly and Tessa Moore. With colleagues at the National Institute for Health and Clinical Excellence, Kelly has been using what evidence there is on public health interventions to produce guidance for local government and its partners. Kelly and Moore strongly reiterate the importance of local authorities contributing to the nascent evidence base through their own rigorous evaluation of their work. Professor Maryon-Davis also takes up this theme in his article, advocating a marriage of public health specialists' skills in data collection and analysis together with local authorities' strong record of community engagement in developing new evaluative methods.

Working together to understand their communities' health profiles and their underlying causes, local authorities and their public health colleagues in PCTs have also begun to recognise the changing nature of a population's ill health. Health conditions relating to poor sanitation and overcrowding have, to some extent, given way to conditions arising from poor food, lack of exercise and the cycle of poor life and health chances associated with the children of teenage parents. This means that, as Professor Hunter notes in Chapter 1, to a certain extent, the local authority functions which can potentially impact most on health have also changed. For example, from sanitation and waste disposal to school meals, social care and support, leisure facilities and accident prevention. This is not to say that the former can be ignored – indeed overcrowding is rising and is once again associated with tuberculosis in the east end of London, as Dorling points out. So although there are new areas in which local authorities can have a health impact, they still have to keep an eye on the traditional social determinants of health – to be watchful and active on all fronts.

There is no doubt that, despite the many activities of local government and its health partners, some of which are illustrated here, there is still huge scope for further work at a local level to tackle the social determinants of health and reduce health inequalities. Most people – even people in local government and even people in public health – still think of the NHS when they think of health services. Part of the purpose of this publication is to help change that thinking, so that local authority councillors, the officers who support them, the health professionals who work with them and the people who elect them will widen their understanding of what really makes people healthy, what really makes them ill and what causes them to die.

When we focus on the social determinants of health, rather than the medical cause of some specific disease, we see that local government services are health services. It is no exaggeration to say that without local government, adults and children would die sooner, would live in worse conditions, would lead lives that made them ill more often and would experience less emotional, mental and physical well-being than they do now.

Nonetheless, despite overall gains in life expectancy across all socio-economic groups, health inequalities are widening and there is always more that local government can do. The chapters that follow show something of the vast range of possibilities that await those with the imagination and energy to harness local government to the service of the population's health – the public policy issue that most people care most about.

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Section 1 – Exploring the issues

1 What makes people healthy and what makes them ill?

David J Hunter
Professor of Health Policy and Management
Durham University

The factors contributing to health and, conversely ill-health are multiple and complex and the subject of much earnest debate among policy-makers, practitioners and academic researchers. But there is now sufficient evidence and agreement to be able to assert with reasonable confidence that promoting good and sustainable health requires particular actions both on the part of individuals and of various bodies and groups engaged in a range of activities and providing a range of services. Occupying a pivotal role among these agencies are local authorities whose contribution to improving health and tackling health inequalities is considerable. Yet, for various reasons and with some important exceptions, local authorities as a whole have not seen their health-enhancing role as uppermost in their thinking or central to their core business. This mindset is changing but, as we enter challenging and difficult territory as far as future public spending goes, it needs to change more quickly.

This chapter examines the social determinants of health and why they remain important. It also explores the puzzle that, despite governments expressing a real desire to tackle these, their efforts are generally disappointing and not up to the task. Too often they end up as lifestyle interventions that target individuals and their health problems whether it is obesity, the effects of alcohol misuse, or growing stress and mental ill-health. Such problems have been termed 'wicked problems' because of their complexity and intractability and because they demand new approaches in respect of tackling them. This chapter then examines the critical role local authorities have in impacting upon these social determinants which goes far beyond their traditional concern with health and safety and environmental health, important though these functions are and will remain. But there is a great deal more that local government can, and must, do if we are serious about tackling health inequalities and improving the health status of our most disadvantaged communities.

The social determinants of health

There is probably no better or persuasive analysis of the contemporary state of affairs in regard to the social determinants of health and health equity than the final report of the World Health Organisation's Commission on Social Determinants of Health. Chaired by Professor Sir Michael Marmot, the Commission's final report was published in mid-2008 (WHO, 2008). The Commission's remit was to gather the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. The Commission adopted a holistic view of the social determinants of health. Essentially, it argued, poor health is the result of the unequal distribution of power, income, goods, and services. It commented on the widespread 'unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns, or cities' – all of which diminished 'the chances of leading a flourishing life'.

The Commission went on to make it clear that there was nothing immutable about these developments – such health-damaging experiences are not an unavoidable 'natural' phenomenon. Rather, they are 'the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics'. In addressing this heady cocktail of factors and remedying the deficiencies identified, national and local governments have a major leading role.

A major misconception that hampers progress is the belief that anything to do with health and ill-health is surely the business of the health sector and, primarily, the NHS. Certainly, the health sector has a vital role to play in tackling the maldistribution of services and access to them (the so-called 'inverse care law') as this is one of the social determinants of health. But the key drivers that account for people's poor health in large part lie, as the Commission points out, in the 'conditions in which people are born, grow, live, work, and age'. Action on poor and unequal

living conditions must involve a range of organisations, including local government, and policies and programmes must embrace all sectors of society and not just the health sector. We know, for instance, that where people live has a major impact on their health. Commonsense alone tells us that healthy places result in healthy people. We know, too, that fair employment and decent working conditions are major contributors to health and well-being. And the evidence testifying to the importance of early years development and education, through initiatives like Sure Start, while not complete, is good enough in terms of pointing to where investment might be made. In each of these areas, local government has a key role to play. It often does play it – though not always for reasons to do with improving health and well-being.

Despite what seems like an endless stream of well-researched descriptions and analyses of the problem, and eloquent and well-intentioned statements of the need to tackle the social determinants of health, successful political action has been less impressive. On this score, the most recent Department of Health review of progress in England over the 10 years since 1998 makes rather depressing reading (Department of Health, 2009). It insists that much has been achieved over this period but there is no disguising the underlying message that though health overall has improved for everyone, including the poor and disadvantaged groups, the gap between these groups and the rest of the population has remained. Indeed, the report states, 'the gap is no narrower than when the targets were first set'. Other evidence suggests that the gap may be widening and with the future economic prospects looking bleak, there are serious worries that the position could deteriorate further. It is an issue the Marmot review, established by ministers at the end of 2008 to consider post-2010 strategy for tackling health inequalities in England, is well aware of, as it prepares its final report for submission to the Secretary of State for Health by the end of the year.

But whatever the commitment to social justice and tackling the social determinants of health enshrined in successive policy statements, the default position has been the need for individuals to take more responsibility for maintaining their health, enabled by government and others through the provision of advice and information to inform healthier choices. The phenomenon has been termed 'lifestyle drift'. It is not so much that such a focus is wrong as that it is, by itself in isolation, insufficient to address the deep-seated and persistent inequalities which exist. Looking ahead, the report highlights that progress against the social determinants of health will be crucial to a long-term, sustainable reduction in health inequalities. Effective action on health inequalities demands action in a wide range of policy areas but in particular on education, employment, transport and the environment. Unless the policy responses in these and other areas are aligned, they have the potential to widen, unintentionally, the health gap.

A key reason for poor progress may be the absence of a strong evidence base in respect of evaluations of wider public health interventions and in particular those policies which affect the social determinants of health and health inequalities. A recent report from the Public Health Research Consortium reviewing evidence from systematic reviews concludes that there is 'some suggestive evidence that certain categories of intervention may impact positively on inequalities, in particular interventions on the fields of housing and employment, though further evidence is needed' (Bambra et al, 2009). Despite gaps in the evidence base, the review pointed out that the most important determinants of health and health inequalities are the wider, 'upstream' determinants. This raises the possibility that government policies in sectors other than health, including housing, education, transport and employment offer real opportunities to improve health and reduce the health gap. In each of these areas, local government has a critical role although one that often requires working in partnership with others since the issues are too complex for any single organisation to resolve. Such issues are often known as 'wicked problems'.

The dilemma of 'wicked problems'

Wicked problems are those which are difficult to define, which straddle many organisations and professions, and for which there are no clear, simple or even known solutions. The problems are complex, multi-causal and multi-dimensional and require action at all levels by numerous bodies and agencies. An excellent in-depth analysis of such an issue in the context of obesity is provided by the Government Office for Science's Foresight report (Butland et al., 2007). It concludes that by 2050 around two-thirds of the population will be obese and that this will put considerable strain on health and other budgets. There is an urgent need to tackle the problem, but it requires engagement and action on the part of all sections of society. Because the causes of obesity are complex, encompassing biology and behaviour, the report says the responsibility for such a state of affairs cannot be pinned on individuals and their lifestyles. It asserts that we have created an 'obesogenic environment' that requires action from government and communities at various levels. 'A bold whole systems approach is critical' and one that requires integrated policies and actions on the part of a range of stakeholders, including local government. Obesity

is not an isolated case and has much in common with other public health challenges.

But like other such challenges, and as noted in the previous section, it is very easy to slip from a concern with the social determinants of health to a narrow focus on individual lifestyle. Regardless of the intentions of government, either national or local, to move 'upstream' and focus on the structural and social determinants of health, interventions all too often end up as small-scale projects or initiatives aimed at changing individual lifestyle behaviour and, in the process, failing to tackle the underlying health determinants on the scale needed to make a sustained impact at a population level. The ban on smoking in public places is a good example of an upstream intervention designed to tackle the problem on the scale required. Initial assessments of its impact suggest it has done more to improve people's health at a stroke and reduce hospital inpatient admissions than any number of local smoking cessation interventions. This is not to decry the useful work often achieved through such measures, but to recognise that, on their own, their impact on the problem is likely to remain marginal. Obesity is another case in point whereby action that tackles the manufacturing and marketing of certain foods needs to go hand in hand with measures which try to help people eat sensibly and exercise appropriately.

The contribution of local government to good health

Traditionally, local government has played a crucial role in public health through its work on sewers and sanitation, food hygiene and environmental health. Such concerns figured prominently in the 'golden age' of public health in the 19th century when huge gains in health were made as a result of bold action on the part of key individuals like epidemiologist, John Snow, and William Duncan, the first Director of Public Health to be appointed in Liverpool. Local government was at the forefront of many of these gains. But with the advent of the NHS and the transfer of much public health activity from local government to the NHS in 1974, local government has often taken a back seat when it comes to improving health and well-being. Anything to do with health has been the preserve of the NHS. But, as we have seen, the contemporary challenges posed by the so-called 'diseases of comfort' require action of a different kind and achieved through other means. These actions rage from cycle routes and vehicle speed limits to anti-smoking measures, leisure services and so on. The NHS has a limited role to play in these areas while local government has a major one. This is recognised by the LGA's Health Commission when it states:

'local authority staff across a wide range of activities – education, transport, planning, leisure, housing, environmental health and social care – have a key role to play in the partnership approach to public health'. (LGA, 2008).

It goes on to point out that 'addressing the problems of relatively poor health among deprived sections of society clearly has a local dimension'.

The Local Government Act 2000 gave local authorities the power to promote social, economic and environmental well-being, thereby placing a renewed emphasis on the role of public health in local government. In recognition of the important and growing role of local government in improving health and well-being, there has been a move since 2006 to appoint directors of public health who are jointly accountable to both the NHS and to local government and who work across the two agencies. While a welcome move, little is known about how such posts are impacting on health. Such posts are challenging in terms of the demands made upon them and the skills required to discharge them effectively (Hunter (ed), 2008). Not all local authorities have favoured such a single post on the grounds that the job is too big and complex for just one person to undertake. Birmingham City Council and Sheffield City Council, for example, have opted to appoint their own health directors to work alongside the DPH located in the NHS. Whatever the preferred arrangement, those leading public health in local government work closely with the local authority director of adult social services and director of children's services whose responsibilities also have a significant health dimension.

Whereas general support for local government's public health role has remained, until recently, rather weak and tentative, this is no longer the case. The Faculty of Public Health (FPH), UK Public Health Association (UKPHA), NHS Confederation and other important advocates for health acknowledge unequivocally that in tackling the wider determinants of health and reducing health inequalities the role of local government is fundamental. It has available to it far more scope and power than the local NHS to promote healthy environments, job opportunities and stable communities. As the president of the FPH put it: "[Local government] can join-up housing, transport, schools, community safety and environment to improve the community's health and well-being". Links can then be made to the health sector through LSPs and LAAs. In a paper calling for a renewed political commitment to health as a public and not just an individual good, the LGA, UKPHA and NHS Confederation stated that local government has the capacity to tackle public health in the

following ways:

- as an employer
- through the services it commissions and delivers
- through its regulatory powers
- through community leadership
- through its well-being power.

The paper considers that this 'vital role' has been 'both obscured and undermined by the policy fragmentation which has separated policy on healthcare from the wide range of policies determining the conditions in which health can be sustained' (LGA, UKPHA, NHS Confederation, 2004). Since 2004, there has been a more explicit recognition of local government's important role in this area which allows local authorities the opportunity to take a lead.

Some functions within local government are more aware of their health role than others. Obviously, those working in environmental health have always been aware of the contribution they are able to make to improved health. But other departments, such as those concerned with urban planning and place-shaping, are perhaps less aware, although the situation is beginning to change. There is growing awareness that sustainable healthy communities require good urban planning and a commitment to what has been termed 'liveability' for healthy communities.

There are other sound reasons for regarding the wider public health and assault on health inequalities as being key functions for local government. A problem with much public health thinking and practice, especially those aspects rooted in a medical model of illness and disease, is that they focus on deficits rather than assets. Many, though not all, public health practitioners, especially those with medical backgrounds, have tended to place an emphasis on identifying the problems and needs of populations that require professional resources and high levels of dependence on health care and other services. In addition, much of the evidence base in pubic health remains dominated by a biomedical approach to understanding 'what works'. It therefore results in policy developments that in turn focus on the failure of individuals and local communities to avoid disease rather than their potential to create and sustain health. Deficit models have their place but the danger is that, coupled with the powerful vested interests of those who subscribe to and actively promote such views, they effectively dominate policy discussions to the neglect of asset models that have more to do with maintaining health.

The target regime operating in the English NHS over the past decade or so has reinforced this bias. For example, in order to meet the looming 2010 target for narrowing the life expectancy gap in England by 10 per cent, there has been considerable effort and investment in secondary prevention, with effort focused on pharmacological interventions, notably statins prescribing among those aged in their fifties and sixties, and other measures to reduce deaths from the big killers such as stroke and cancer. There is, of course, a place for measures of this sort targeted on groups who have been overlooked or neglected in the past. Indeed many areas, notably Sheffield but elsewhere too, have made impressive inroads into tackling health inequalities as a consequence of such means. But these measures focus on treating symptoms rather than getting to grips with underlying causes and can hardly be regarded as evidence of good public health.

The focus on individuals has also been reinforced by a shift since the publication of the national strategy, *Choosing Health: making healthier choices* in 2004 from upstream to downstream action with a stress on personal responsibility and promoting individual behavioural approaches. This renewed focus on individuals also chimes with a biomedical downstream approach. Ideally, a more balanced policy response is required and it is in achieving this that local government has an especially critical role to play. An asset model such as that discussed by John Ashton in Chapter 9 would take as its starting point the need to identify and build on the positive features of individuals and communities, utilising such capacities and capabilities as exist to further empower them.

At the risk of being over-simplistic, the NHS deals with the negative outcomes of people's health experience (it is, after all, a sickness service) whereas local government eschews 'quick fixes' and looks for positive patterns of health in respect of strengthening those social bonds and ties that go far in sustaining health, even in the face of disadvantage. Assets can operate not just at the level of the individual but, importantly from a local government perspective, at the level of the group, neighbourhood, community and population. These assets can be social, financial, physical, environmental, educational, employment-related and so on. Conceived of in these ways, they relate directly to the social determinants of health discussed at the start of the chapter. Worth recalling, too, are the recommendations of the Acheson inquiry into the inequalities of health published in 1998. Of the 39 recommendations put forward, only 3 directly concerned the NHS or were within its power to influence directly. This rather makes the point that, when it comes to the wider health agenda, the NHS has a somewhat limited role.

Conclusion

Health inequalities between the least well-off and the better-off are growing in the UK despite the government's commitment to tackling them. Part of the mismatch between the policy goal and the reality in practice is a failure, for numerous reasons, to get a proper grip on the social determinants of health. Tackling health inequalities through the NHS and secondary prevention, though important and necessary, will not in themselves be sufficient to narrow the health gap. Rebalancing health policy to accord a higher priority to the wider public health requires local government, as well as national government, to assume a greater responsibility for enhancing the health status of their communities. Much good work has already been achieved, or is in hand. Some of this has been documented by the IDeA's healthy communities initiative. But there remains a concern that local government has a great deal more to contribute to the health agenda than has yet been realised. Paradoxically, the gloomy economic outlook from 2011 also brings with it hope for a step change in how local government regards its role in improving health and well-being. As Barack Obama's Chief-of-Staff, Rahm Emanuel put it: 'Let's not waste a good crisis'.

References and further reading

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2 Using the concept of 'place' to understand and reduce health inequalities

Danny Dorling
Professor of Human Geography
University of Sheffield

"Health-related behaviour is all about resolutions to give up the things you do not want to give up and to do the things you do not want to do. You cannot do that; you cannot make the resolutions and stick to them, unless you are feeling on top of life."

(Richard Wilkinson giving evidence to the House of Commons Health Select Committee, 2008)

It is hard to feel on top of life if you know that where you live is looked down upon, if you know that you are treated less well because of where you live, if you know people think less of you because of where you live.

In the report of his recent review of local government, Michael Lyons' states that "The concept of 'place-shaping' is intended to explicitly recognise the fact that local government is not an agency, responsible for delivering a specific set of statutory services. Rather, it is a unit of government, responsible for the well-being of a community and a place, and independent of, whilst also being connected to, the wider system of government. Local government's role should therefore be about engaging with and representing communities, building coalitions, and influencing the actions of other public, private and voluntary sector organisations, as well as delivering or commissioning local public services" (Lyons, 2007). Given this, understanding in detail the social and economic characteristics of geographical areas is an important tool for local government in influencing the health profile of their areas.

Since at least 1968 in the UK, inequalities in local service delivery have contributed to growing spatial social polarisation. There is a very long tradition of work that demonstrates how poorer services are provided to people in poorer areas. This work continues today, repeatedly showing that the most qualified teachers and the highest number of doctors are more likely – on average – to be working where there is less need for their services, even when funding for their provision is entirely controlled by government. This has become known as the 'inverse care law' which David Hunter refers to in Chapter 1.

What has not been shown clearly to date is how these inequalities exacerbate local inequalities by encouraging people to segregate more and more by wealth, both locally and nationally. We have yet to prove that these correlations are at all helpful even to the people who appear superficially to benefit most - those who gain access to medical staff more easily because there are more staff where they live, or whose children are taught by 'better' teachers. And we have yet to show that we have the ability, collectively, to address these problems.

It is very possible that living in an unequal society hurts everyone, including those who appear to benefit from being a resident of the leafy suburbs. Suburbs that rank similarly in more equal affluent countries than the UK are home to people who have better levels of health, education and well-being than those of the British and Northern Irish despite (or perhaps because) of the fact that they less beggar their neighbours. These better-off suburbs are found in the majority of OECD countries, as most OECD countries are more equitable than the UK (Wilkinson 2009).

The relationship between the various scales of geographical inequalities and health is not always well remembered. Within any country there are health inequalities that are differentiated geographically. Even in quite equitable countries these tend to be stark, if less wide. That is because better-off people do so much better, and tend to enjoy so much better health in more equitable countries, as compared to better off people in more unequal countries. Pretty much all the social determinants of health discussed in this publication are geographically differentiated.

Public services play a role at the local level

What makes an area more desirable? Many things. People often say that, if they had a choice over where to live, they chose their home because they liked the look of the house, the décor, it was on a 'nice road', had the right number of bedrooms, 'felt right'. However, when house prices are modelled a series of local factors are usually found to matter greatly. Chief among these are the following five, most of which directly or indirectly relate to good and poor local services or environments:

- Perceived quality of local schools (raising house prices by private school fee amounts in areas with the 'best' state schools)
- Amenity of local services such as health and social care

(areas without stretched services do well)

- Housing type (for example detached) and 'the neighbours' (owner occupiers are preferred to, say, students)
- The availability of employment – which is key to the gradient in prices away from many cities
- A sense of safety, and community. Does the area appear to have little crime, safe roads, less graffiti, less mess on the streets?

For many people some of the most important aspects of these services are provided by or strongly influenced by local government. All of them are also determinants of health. And when services are not very good, they both help maintain inequalities and can increase them. Here are some of the ways.

State schools

Ninety three percent of children go to state schools and they now come in as many varieties as there are of Heinz tinned goods. People have become more polarised over time between areas as they fight for better schooling for their children. The creation of an apparent market in local state schools makes it appear to parents even more important than it was a few years ago to try to live in the best 'catchment area'. Scotland provides a model of how good local education can be better spread than England has managed to achieve.

Health and social care

Well over 93 percent of people use the NHS for illness that really matters; 100 per cent use the NHS for accident and emergency. GP centres matter most. There are still most GPs where they are least needed, where people have the best health. Conversely, almost every social services user is either someone whose future health is threatened by the conditions in which they live, or someone who is already suffering from some form of ill health which affects their daily life (Bywaters, 2009). The geographical spread of social services users can be estimated by considering the spread of those working in social services and knowing the direction of their commute to work from the census – the service users are heavily concentrated in the poorest areas. Financially the bulk of the money spent on social services goes on the salaries of those who provide the services who mostly live (and whose spending is mostly) outside of these areas.

Social housing

Social housing has a much larger influence on concentrating those who are ill, or become ill, than many think. A local authority audience may realise this but the bulk of the population do not. Some five million will soon be on waiting lists to be housed nationally; most do not expect to be. Roughly a fifth of households are in local authority tenure; its absence serves as a magnet attracting people with money to live where social housing is absent, again increasing spatial social polarisation and, consequently health polarisation. The numbers of other registered social landlords and the wholesale transfer of much local authority housing muddies the waters a little, but again this housing tends to be concentrated in poorer areas. Government does have a scheme for transferring from owner occupation to social housing tenure, but by mid 2009 this had resulted in the transfer of fewer than a dozen homes in the country. The right-to-buy has polarised areas by tenure over time. Lack of an effective 'right-to-sell' your home to a social landlord, to stay put and become a tenant rather than be evicted for mortgage arrears is one of the key missing mechanisms that ensure spatial social polarisation and hence geographical inequalities in health continue.

A 'right-to-sell' is the right to sell owner-occupied housing to the local authority or another registered social landlord. The former home owner becomes a tenant and avoids repossession. This would quickly diminish the cachet of owner occupied ghettos. If enacted carefully so that the right was dependent on the home not being too large for your family, then this would also make better use of the overall housing stock.

Within some cities, especially London, overcrowding has become much worse over the last 20 years. This will have had a detrimental effect on people's mental and physical health. It is likely to have contributed to the recent increase in tuberculosis, for example, in the East End of London. It will also have contributed to the geographical concentration of deprivation and poverty. "Over one million children are now trapped in overcrowded housing, a rise of 54,000 in the last two years" (Shelter 2009). Children in overcrowded housing are up to 10 times more likely to contract meningitis than children in general, Shelter notes. These infectious diseases such as meningitis and TB are then greater risks to all. It is simply in the interests of everyone in Britain not to see overcrowding of poorer families occur as it has. The only reason why overcrowding has increased is that a greater proportion of the overall floor space of housing in Britain has been consumed by the best- off over the course of the last two decades. There has been no overall decrease in housing supply.

At the same time, the way in which we currently use housing so inefficiently in the private sector means that there has been a great lack of investment in new build by local government. Private sector inefficiency results in those

who have most money having most floor space and in some cases owning many homes, many of which are mostly empty. Government is currently consulting on a new system for council housing finance which could return a greater direct role in building to local government. This is an opportunity for a 'facelift' for some of the worse off areas and is also an opportunity to spread social housing around more geographically, so as to avoid creating ghettoes of the future. Allowing mortgagees facing eviction the right-to-sell to become tenants would quietly and very efficiently begin to break up the owner occupied ghettos we currently have.

The local authority as employer

Direct state employment matters. Median wages are higher in the public than private sectors. Of all workers, 20 per cent are directly employed by the state. Local government negotiates wages and terms and conditions of employment with trade unions, as well as having requirements to promote equalities, whereas private employers, now competing for lucrative local government contracts, often do not. Successive Governments have forced local authorities to outsource many services, with this inequality becoming exacerbated year after year. Reversals only occur in times of crisis. In many areas, a local authority will be the second highest employer (often after the NHS). Local authorities provide work closer to people's homes than they might otherwise find. This can be in schools, waste disposal, neighbourhood offices, and various enforcement and inspection roles. As an employer the local authority role in reducing geographical inequalities often gets overlooked – employment is highly correlated with health and well-being. When a local authority in summer 2009 suggested reducing the incomes of men who collect rubbish bins so as to equate them with women, the authority was thereby suggesting reducing incomes in many of the poorest areas of the city, where disproportionate numbers of bin men live. If two successive Mayors of London from two different major political parties agree that the Greater London Authority and any of its contractors pay the London living wage then no one else has an excuse to be ineffective.

Crime, accidents and safety

In terms of safety, and how it is perceived geographically, the local public sector has direct input via the police (and now through crime and disorder reduction partnerships), but the police do little to make one area safer than another. In particular they do very little to reduce the perception that certain areas are very dangerous. When the police disseminate crime statistics they rarely say how unlikely you are to be burgled, even in the poorest of areas, as compared to your chances of other misfortunes. Crime statistics are routinely released to local bodies and appear in 'area newsletters', typically revealing the number of cars that were broken into the previous month.

A better statistic might be to tell people that their chances of having their car broken into were one in five hundred last month, and say how low that is compared to their chance of being involved in a road accident. Everyday car drivers - rather than the vicious criminals of fiction - are the greatest killers of people in Britain. Of any single cause, the greatest killer of people aged between five and 35 is car accidents (Shaw et al. 2008). Most children who die, die at the hand of a stranger who was just driving to work. It is only local government that can take effective action to reduce this. Almost all local road speed reduction and traffic management is directly done by local authorities. Cars travelling at 20mph rarely kill children they hit. Cars travelling around 30mph or more often kill and very severely injure.

Anyone working in local government who thinks they have little power should ask themselves who has the most power to stop the way in which most physical suffering and early death occurs to children in Britain when they are hit by a car. Five to seven times as many children are killed by cars in the poor quarter of cities as compared to the rich. But in the rich areas children are no longer allowed out to play so they suffer in other ways too from the way we run our local environments. Oxford, where I was brought up, is likely to be the first all 20mph city. Not only will that save lives in Oxford; but poor areas in that town will increase slightly in amenity, while living in a twee village out of town will reduce in value just a little, so the speed limit will have an equalising effect.

Area-wide traffic calming schemes are one of the few pedestrian injury prevention strategies for which there is documented evidence of efficacy (Davis 2009, National Children's Bureau 2004). Traffic calming, design which encourages cycling and discourages car use and parking in the least affluent areas are all part of the contribution local government can make to improving health and reducing health inequalities. Telling local people that you are going to reduce the greatest risk to the lives of local young adults and children would alter ideas such as the perception of crime and safety. We know this is a determinant of how people see their area and also contributes to mental well-being. Supposing local authorities said to people in their poorest wards that they were no longer going to allow the rich from outer suburbs to speed at 40mph through the inner city? Everything from that to graffiti and dog dirt are part of local government's environmental responsibilities, and all are issues that contribute to people's perception of crime and safety.

Pollution

Before government controlled pollution it was often the areas to the north east of towns which were the most effected by smog. These are still often the poorest areas and the south west still often the richest. And although we don't have smog any more, pollution from vehicle exhausts and noise remain environmental issues which local government has powers to regulate. The closer you live to a main road the more pollution you will suffer and, in general, poorer areas have worse air quality (Mitchell 2003).

Rates of recycling are higher and rates of pollution, including green houses gases, are lower in more equal countries. To give a simple example, in a more equitable country the affluent feel less need to drive their children across town in a four-by-four to go to a school that avoids them having to mix with other children who are much poorer. Reducing local inequalities within any town reduces the felt need for such anti-social behaviour. Local authority-financed state schools are least used in Inner London, Oxford and Bristol because these are some of the most unequal of British cities, and so early morning car congestion and pollution has become endemic in parts of these cities. States schools are used more often, including walking to the nearest state school, in more equal countries.

Of all the 25 richest countries in the world, the US and UK rank as 2nd and 4th most unequal respectively when the annual income of the best-off tenth of their population is compared with that of the poorest tenth. In descending order of inequality the 10%:10% income ratios are: 17.7 Singapore, 15.9 United States, 15 Portugal, 13.8 United Kingdom, 13.4 Israel, 12.5 Australia, 12.5 New Zealand, 11.6 Italy, 10.3 Spain, 10.2 Greece, 9.4 Canada, 9.4 Ireland, 9.2 Netherlands, 9.1 France, 9 Switzerland, 8.2 Belgium, 8.1 Denmark, 7.8 Korea (Republic of), 7.3 Slovenia, 6.9 Austria, 6.9 Germany, 6.2 Sweden, 6.1 Norway, 5.6 Finland, and 4.5 Japan (UNDP 2009, excluding very small states).

Japan has the most mixed communities of all these countries, the lowest levels of pollution, highest rates of recycling, lowest car use and the most children walking to their nearest school. We should stop looking so often to the US for ideas on how to make local communities and health better.

School meals

Here is one example of what is being done with school meals:

"The vision for the Online Free School Meals (FSM) project is of an 'end-to-end', citizen-focused service that transforms the way in which eligible partners are supported in ensuring that their children receive a free school meal. The project, which has involved Hertfordshire CC, Tameside MBC and Warwickshire CC in developing proof-of-concept models, is a genuine opportunity for government to demonstrate, in a key area, that it can work collaboratively to make services simpler, and quicker to access and deliver."

(IDeA 2008, p37)

We could also add the example of 'breakfast clubs':

"Some UK clubs have managed to attract children from disadvantaged backgrounds without stigmatising the children. Success has been attributed to an inclusive approach and hard work on the part of teaching staff, parent volunteers and other service providers to ensure that 'joining the club' (as opposed to 'attending a school-based service') was seen as a positive choice for those attending and their families."

(National Children's Bureau 2004).

Eating breakfast has been associated with improved academic outcomes, improved concentration, increased school attendance, decreased school lateness and improved mood at school, thus contributing simultaneously to both health and educational goals. It would also help if local authorities as employers tried to make sure that they enabled their employees who are parents to have breakfast with their children. Employing more people at school friendly hours, including term time only, could be cheaper than employing them nine to five.

The obvious solution is simply to have school meals, including breakfast, free to all who want them. Introduced after the Boer War, means-tested free school meals were a solution for another age. We don't have free school chairs or tables for means-tested children while others pay for their chairs and tables or bring them in from home. Free schools meals for all has been extensively trialled and found to work in Scotland. In England all primary school children in County Durham and the borough of Newham are finally now being given free school meals in a trial for a nationwide scheme (Teachernet 2009).

Local authorities have the key role to play

In a city like Sheffield, it is much better state schools, better access to services such as doctors, not having to live near tenants, massive state employment, and a huge amount of traffic calming and management that makes the south west of the city attractive. Over the years, Sheffield and most other cities in Britain, have slowly become more socially polarised as a result.

The ability that local authorities have to save the lives of children by simply putting up 20 mph signs is just the tip of a great pyramid of actions that can increase well-being. In short, the most important levers affecting the desirability of different residential areas and, consequently, their health profiles, are in the hands of government and especially local government.

If living in the suburbs did not bring with it better schools; if the commute to work was much slower by reduced speed limits through inner city areas; if people in the suburbs could become council tenants by exercising a 'right-to-sell'; if living in the suburbs were not so much more preferable to living in the city in terms of the local services provided by the state, then would local social polarisation continue to increase as it has for forty years? If you could get to see a GP just as easily by living in the middle of town; if your local primary school had an extra assistant in each class because of the needs of its intake; if enough streets were shut off to allow your kids to play outside, and traffic in others slowed down; if they paid you a decent wage for collecting the bins, why not stay on that street rather than leave when you can?

The national government can decide whether tax and benefit systems should be continued so that the UK is a more unequal country in terms of income than another 20 of the 25th richest countries on earth (including even being more income inequitable than Israel). But local government holds most of the cards when it comes to what is needed to reduce spatial social polarisation. It has tremendous power to make people's lives better, through measures as varied as the living wage, air quality management, school meals and speed limits.

From local to national: growing geographical inequalities

The social polarisation taking place on local levels is a strong trend that is also driving national-level inequalities. A group of colleagues from the University of Sheffield and I have recently explored this polarisation as part of the 'Changing Britain' project, funded by the BBC[1]. We mapped a series of social trends from as far back as 1945, according to BBC TV and radio areas.

As local authorities engaged in activities at regional and other levels and as partners such as the NHS are aware, it is not always helpful to think of local areas in terms of local authority boundaries. The regions covered by local TV news and the cities covered by local radio stations tend to have better local identities than do smaller council areas. The BBC's TV areas look like this (the map on the right is a cartogram with area drawn in proportion to population):

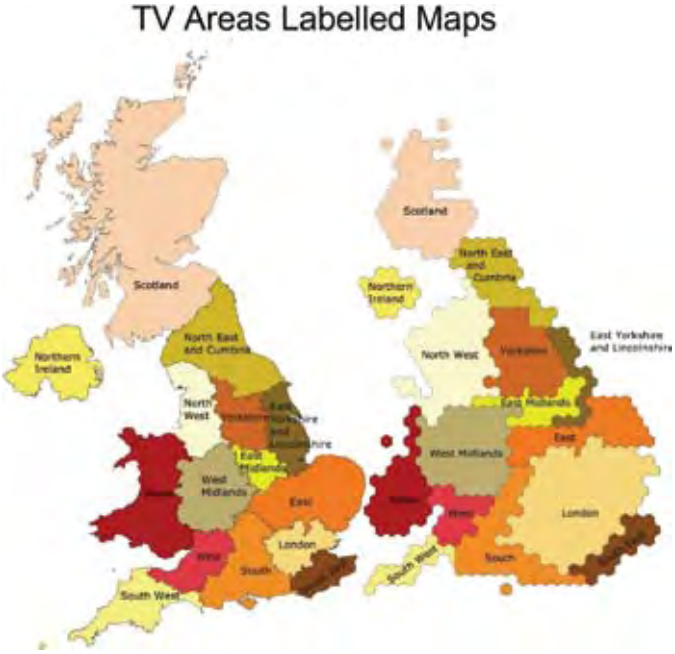


Figure 1

In the map on the right each hexagon is a parliamentary constituency.

The BBC radio areas look like this (the map on the right is a population cartogram)[2]:

The equivalent population cartogram for local government is very complicated and messy and not very useful for looking at inequalities across the country. So I invite readers to think 'BBC area' instead for the next few pages.

By using this geography as a basis, you can see very simply how population has changed over time in Britain and where

1 This work was undertaken by members of the social and spatial inequalities group at the University of Sheffield including Dan Vickers, Bethan Thomas, John Pritchard, and Dimitris Ballas. The same group also released a report on inequalities in one local authority (Sheffield) as an example of the extent of an audit that is possible of inequality in one place (Thomas et al, 2009).

2 We have created some fictitious radio regions for Scotland and Wales to be comparable to those in England.

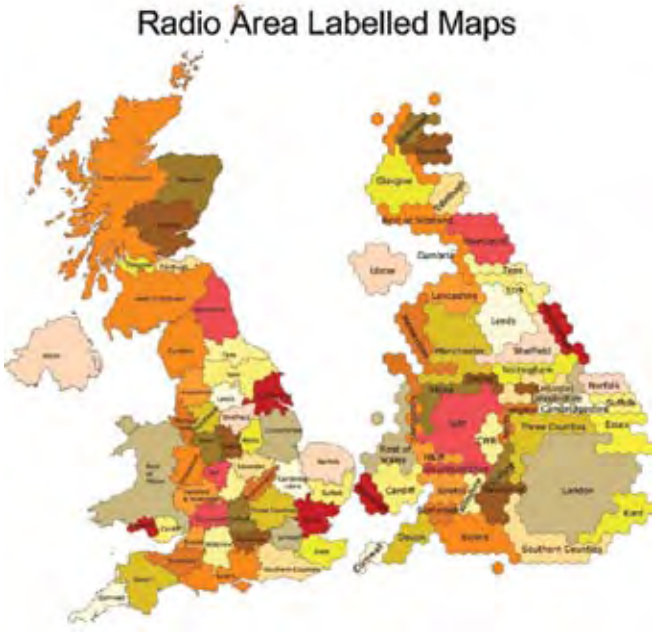


Figure 2

we are sharply diverging – be it by population size, age or wealth, poverty or health. For example, Figure 3 presents population movement between 1981 and 2006.

Notice that, when shown by radio area, it is mainly within the south that population growth has occurred. Such change has had the effect of sharpening up the north-south divide when the largest increases have been near that border.

There was little a single local authority in the North West could do to attract more migrants from abroad when it needed them, once migrants had learnt there was more money to be made in London. But maps like this show how national policy affects local areas, their character and needs and why, therefore, local government should understand its impact. The overall pattern of population change has over the longer term been very smooth, geographically. Monies, posts and aspirations have followed this pattern, but it was not a natural move to the south. Successive governments supported the move. It was reinforced by the growth in the finance industries and the decline of manufacturing. But there is no inevitability that this will continue. It all depends one what we choose. Whether we build third runways or support a 'defence' industry based mainly in the south, with faster rail lines into London. Or do something a little more imaginative. Currently government is choosing to reduce £300 million of spending in the North of England to spend most of it mainly bolstering the housing market in the south (Audit Commission 2009). I would be interested if anyone can find a clearer example of how action by

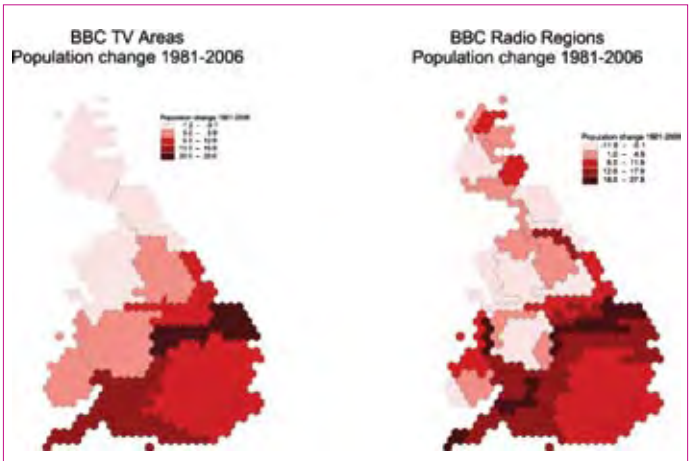


Figure 3

central government helps maintain the north-south divide.

Figure 4 (overleaf) shows the geographical picture of population spread by age, just for 2006. Note also that, by 2006, London became the place to be up to age 44, and the place to leave most clearly after that age.

It is not just as simple as population movement, and the divergences between where old and young live. The gaps have also been growing according to wealth and poverty and health between different parts of the country - as well as within cities.

The maps below give the latest detailed picture we can create of social inequalities prior to the release of the 2011 census data. Complex methods of combining censuses and surveys are used to draw these maps and to chart the slow and steady polarisation of people by poverty and wealth (and, consequently, health) between areas.

The important point to make when we look at these kinds of cleavages is not simply that the totals are increasing, but that the differences between areas are growing more extreme. People and places in Britain are not characterised just by standard understandings of poverty and wealth and all that correlates with them. They are other key cleavages, such as loneliness – a negative indicator of mental health – which is also growing more extreme in some areas more than others. We have found that, between different, small areas, loneliness rates have diverged over time (Dorling and Gunnell, 2003). Loneliness would be a good measure against which local authorities could assess their communities' sense of well-being in their annual quality-of-life surveys. These kinds of measures of social fragmentation are an attempt to quantify social glue and social atomisation. In the case of the latter, measures are rising.

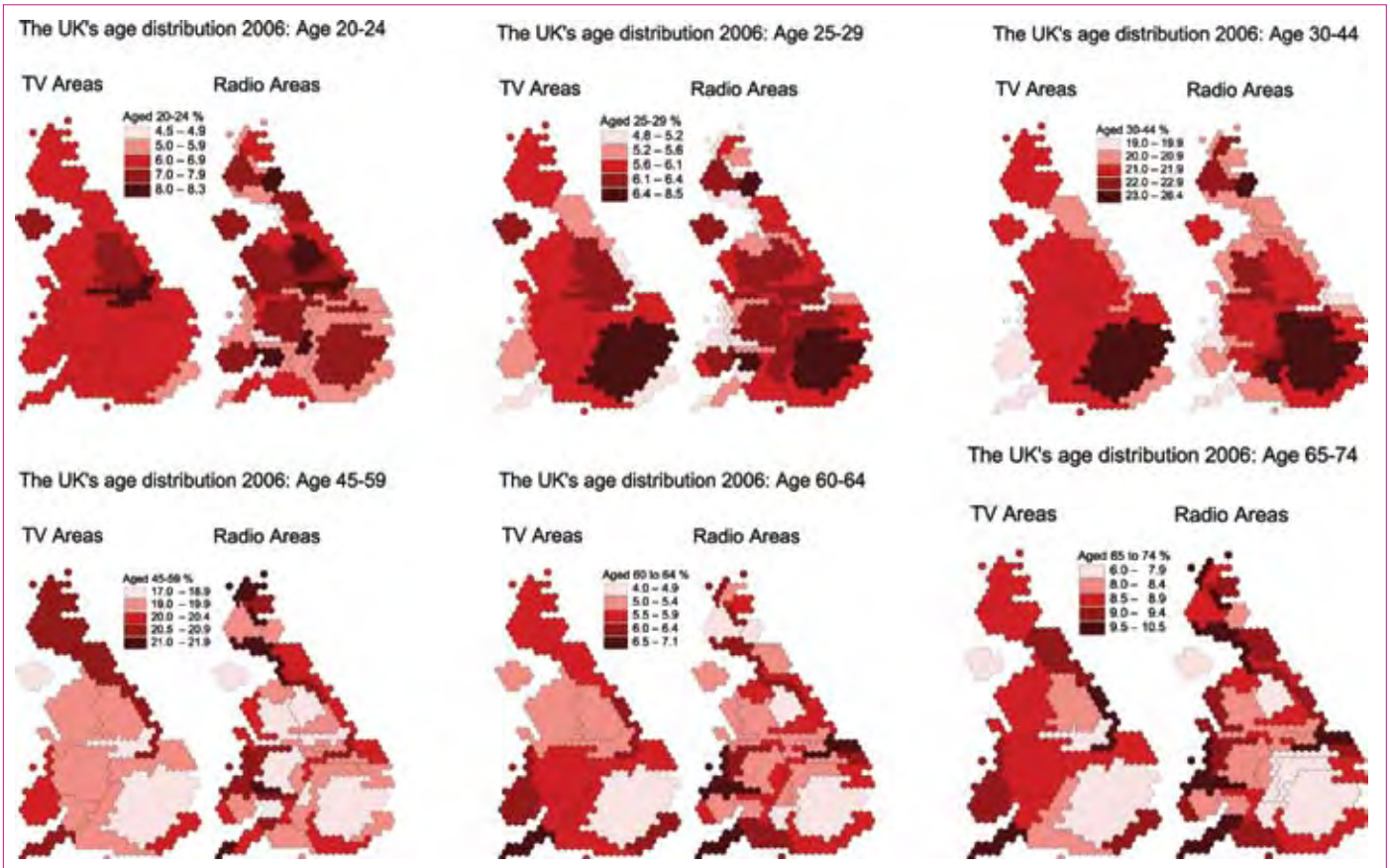


Figure 4

Would the public welcome action?

In the run up to the 1997 general election there was an upwelling of feelings of community, of 'all being in it together'. From 1997 to at least 2005 that sentiment declined as Figure 6 shows, with selfishness winning again

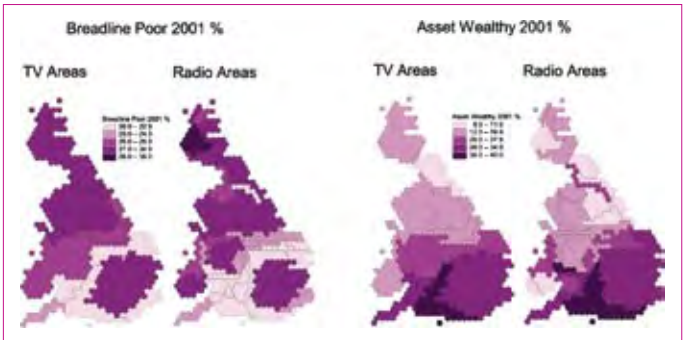


Figure 5

by 2005. But by early 2007 the position had reversed again. Long before former certainties began to crash around us (of financial and social stability), people at the very first signs of trouble began to say again that looking after the community should come first.

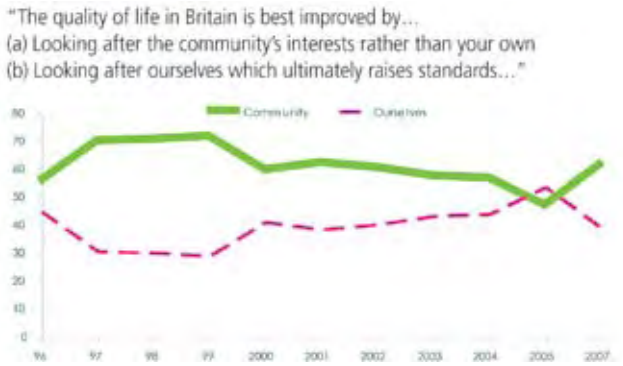
People are beginning to change their priorities slightly in light of issues such as rising potential loneliness, stress, and because in many ways we have now become affluent enough to cover our basic needs and are realising that we should be looking for more from life than simply trying to earn more or live further away from our neighbours. Consider how The Futures Company *Planning for Consumer Change* found attitudes to work to be changing at the very start of the current down turn:

Today we see some core British and American values (materialism, individualism) being drawn into question. Consider how attitudes to consumer choice are changing:

This research into perceptions reveals a public appetite for the state to play a bigger role in improving people's increasingly unequal lives, to reduce the uncertainties in life, to reduce inequalities.

Conclusion

The 'place-shaping' role of local government could take advantage of this appetite for change to bring about greater levelling up between areas. Local authorities are the planning authorities for their areas and, as such, have huge opportunities to influence both the infrastructure and the

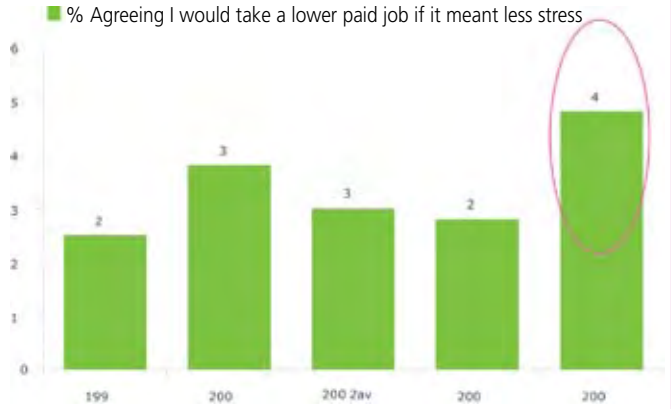


Source: The Futures Company *Planning for Consumer Change* 2007. Note that this chart excludes 'don't know' and 'not stated' which account for 16.5% and 0.5% of respondents, respectively by 2007.

Figure 6

services provided in an area and how they in general 'feel' as a pleasant, or otherwise, place to be.

Local authorities are now using the planning function to design in walking and cycling routes and opportunities for exercise, to cut down car use, ensure that health and social care facilities are put in place in large developments, and build in safety factors (and safety perception factors) such as street lighting. Again, just think of a single child saved from injury and suffering by a 20 mph sign. Local government decision makers really do have the power of life and death in their hands.



Source: The Futures Company *Planning for Consumer Change* 2007.

Figure 7

Within Britain, differential migration, year by year, slowly adds to the social division within and between local authorities. The perpetuation of old state systems such as free school meals for a few and perceptions of social housing as low-quality, maintain the engine of divisions. And all of these maintain and increase inequalities in health.

Source: The Futures Company *Planning for Consumer Change 2007*.

Figure 8

Implications... for local services

The state needs to be brave and to devise new ways of doing things to slow down growing spatial inequalities. The implication for local government is a commitment to increasing services and increasing resources most in the poorest geographical areas: differential treatment to correct the 'inverse care' law. Otherwise the impact of the social determinants of health will continue to increase health inequalities between geographical areas, increasingly poor mental health and worse overall health for all. If the national government concentrates resources in the south of England through housing market packages and bank bailouts, this is unlikely to reduce overall geographical inequalities in Britain.

Implications... for the evidence base

The work presented here has involved some speculation, but also a great deal of background reading and the use of the comment as above re writers style work of many others (Dorling 2010). More precisely it also requires bespoke methods for estimating poverty, wealth and health locally – otherwise we would not know that the country is slowly dividing between rich and poor areas and, therefore, between healthier and sicker areas. We need innovative research, as Mike Kelly and Tessa Moore argue in Chapter 3, and we need to pull together the enormous range of evidence already out there more imaginatively.

Local authorities have, since 2008, been required to work with the local PCT in producing a joint strategic needs assessment (JSNA) for their area. This is supposed to produce a profile of the area, along the dimensions I have been discussing, including, obviously, health and social care needs. It is supposed to inform the 'LAA', that is, the set of indicators and targets that 'partners' locally agree to work on. The requirement for the JSNA, and the general requirement for local government and the

regional public health observatories, to understand their populations emphasises the importance of doing the kind of mapping, charting and graphing illustrated here – it will increase as the authorities' own understanding of the links between health and other social/economic factors increases and will also increase the understanding of the populations themselves and their elected and community representatives and, perhaps most importantly, help set priorities for design and provision of services.

With colleagues we have been looking in great detail recently at inequality within the city of Sheffield, with results published on the web in November, 2009 (Thomas et al 2009). Slowly, surely, it is possible to use the concept of 'place' to understand, and suggest it is possible to reduce, health inequalities. Just because we have been so bad at this in Britain in the past four decades does not mean that doing better is not possible.

Acknowledgements

This chapter was based on a report for IIPS, first title: 'Working towards better outcomes in local service delivery'. I am very grateful to Dr Fiona Campbell for her great patience in dealing with several drafts of this chapter and very many helpful suggestions she has made.

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3 Making a difference: using NICE guidance and embedding evaluation

Michael P Kelly
Director of the Centre for Public Health Excellence,
National Institute of Health and Clinical Excellence (NICE)

Tessa A. Moore
Head of School Improvement at the London Borough of Richmond

Local government has a fundamental role to play in the promotion of health and the prevention of disease. In Britain, public health originated in local government. The history of public health in nineteenth century Britain and the corresponding improvement in the health of the population is closely linked to the history of local government reform and improvement. From the care of the needy and destitute to the provision of clean water and sanitation, local government played a pioneering role (Gairdner, 1862; Frazer, 1947). Indeed the case has often been made that the efforts of local government did more to improve the health of the population than the activities of the medical profession through most of the nineteenth century (McKeown, 1976).

To this day the actions of local government can ameliorate the impact of the wider determinants of health, promote good health and prevent disease. Whether it is housing, education, environment, planning or regulation, the local authority has a contribution to make. The actions of local authorities impact on the everyday lives of ordinary people. The places we live in, work in and relax in are critically regulated, managed, controlled and/or monitored in various ways by local government. Some of the potential hazards that surround us are often critically moderated, or sometimes made worse, by the actions of local authorities, for example dangers linked to alcohol and fast foods. This paper considers how local government can make the best use of the guidance produced by NICE on these and other issues as a way of making a difference to the health of local populations. It also makes the case for local government to do more and better evaluation of interventions.

NICE began its public health work in 2005. It has since produced a range of guidance aimed specifically at various parts of local government. NICE's guidance is also aimed at the NHS but the focus here is what NICE says to local government.

The published portfolio of NICE public health guidance is extensive. It majors on the kinds of public health problems that produce a considerable burden of disease, that show a strong social class variation, and which are amenable to action designed to prevent, detect and protect from disease. Topics include:

- physical activity
- smoking and tobacco
- sexual health
- alcohol
- drugs
- maternal and child health
- health and work
- older people's health
- cancer
- immunisation
- accidental injury
- obesity
- mental well-being
- cardio vascular disease
- diabetes
- communicable disease prevention.

The NICE public health guidance (see box below) on a range of issues is of particular relevance to local authorities. Also of interest will be the upcoming guidance on child accident prevention, preventing heart disease and diabetes, schools and the prevention of the uptake of smoking, spatial planning, transport policies to promote walking and cycling, looked after children and personal social and health education.

NICE published its guidance on obesity in 2006. It contained a considerable number of evidence-based recommendations about obesity prevention of direct relevance to local authorities. The guidance addressed the ways that schools should be involved in obesity prevention. The recommendations dealt with building layout, recreational spaces, catering, vending machines, physical

education, the curriculum, school travel plans, staff training and the overall healthy schools approach. Of course the guidance acknowledged the considerable degree of independence which schools enjoy from local authorities, but as a framework for Children's Services, as a set of guidance of relevance to the school advisory service, the guidance provided the most up to date and evidence-based assessment of the key ways to tackle obesity in schools. The guidance also dealt with early years settings where it discussed improving levels of physical activity.

The guidance encouraged local government to take responsibility for managing obesity in its own workplaces. This included developing policies and plans relating to healthy eating, physical activity and safe environments, encouraging active travel, promoting and supporting physical activity, promoting healthy foods and developing community-based programmes to help to achieve these ends. The guidance contained advice on working with self help and commercial organisations. Local authorities were encouraged to think about building design, for example making stair use more readily and easily available and by having changing facilities and showers readily available.

To get a flavour of the issues dealt with in the other guidance, see for example the work on community engagement. This details the importance of setting realistic timescales, putting proper funding in place and ensuring proper evaluation is conducted. The guidance majored on issues of power, trust, culture, training and partnership working. The guidance on physical activity and the environment focused on transport, public open spaces, buildings and schools. The guidance on physical activity and young people considered the evidence and made recommendations about active travel, the curriculum, space, facilities and equipment, policies and evaluation. In the guidance on mental well-being and older people, one of the elements considered is how best to get older people physically active by walking and getting involved in walking schemes of various kinds.

One of the very important things the NICE public health guidance does is focus on health inequalities. This can be helpful for local authorities. As this publication demonstrates, the relationship between the wider determinants of health and general patterns of health and health inequalities is very well established (Marmot & Wilkinson, 2006). At a general level the importance of social justice, fairness, basic standards of service, and adequate levels of income can be described quite easily. But the imperative for local government to deliver on the health inequalities agenda and the importance of targeting services effectively requires more than general principles. The NICE guidance builds a detailed consideration of health inequity into its assessment of the evidence and the recommendations.

This is important because interventions designed to tackle the problem of health inequalities are particularly tricky. In order to maximise the effectiveness of interventions designed to deal with health inequalities several considerations must be borne in mind. Different segments of the population respond in different ways to similar interventions. Therefore the whole health gradient, not just the most disadvantaged, needs to be factored into the intervention. To maximise health improvement we need the health of the population as a whole to improve, but the health of the most disadvantaged to improve at a more rapid rate (Graham & Kelly, 2004). To do this requires a good understanding of the nature of the different segments in the population and their different needs. This is where the NICE guidance can provide useful frameworks for action.

NICE guidance on public health

Guidance aimed at various parts of local government: http://guidance.nice.org.uk/PHG/Published

Forthcoming guidance on child accident prevention, preventing health disease and diabetes, schools and the prevention of smoking uptake, spatial planning, transport policies to promote walking and cycling, looked after children and personal social and health education: www.nice.org.uk/Guidance/PHG/InDevelopment

Prevention, identification, assessment and management of overweight and obesity in adults and children: http://guidance.nice.org.uk/CG43

Community engagement: http://guidance.nice.org.uk/PH9

Physical activity and the environment: http://guidance.nice.org.uk/PH8

Physical activity and young people: http://guidance.nice.org.uk/PH17

Mental well-being and older people: http://guidance.nice.org.uk/PH16

Methods for development of NICE public health guidance: www.nice.org.uk/media/FB9/59/PHMethodsManual2006.pdf

The way in which public health guidance is produced is by searching for and synthesising all the evidence relating to a particular issue. The evidence is assessed to determine its quality. Then, independent advisory committees use the

evidence to craft recommendations. Assessing the evidence in this way disentangles the things that improve the health of the population and things which determine inequalities in health.

As NICE has produced public health guidance there have been several challenges. Most obviously local government and education have not traditionally looked to NICE to provide this kind of advice and guidance. But more fundamentally the nature of the evidence relating to these issues is much more complex than that relating to medical interventions. It is sometimes argued that determining the effectiveness of interventions in education, social care or even environmental health is impossible. This is because the kind of evidence that is thought to be needed, especially randomised controlled trials, cannot be undertaken. Therefore it is alleged there is not an evidence base that can be turned to with confidence.

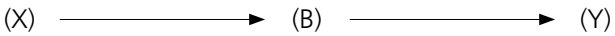
This argument is wrong on several counts. First, NICE takes a broad approach to evidence relating to public health and does not confine itself to data derived from trials. It considers the best available evidence. Second, although the systems of local delivery are complex, and the ways the wider determinants of health operate are complicated, that does not mean that it is impossible to make evidence-based recommendations. The NICE public health guidance has identified many actions at local, community, individual and national level which, if implemented properly, would lead to health improvement and to reductions in health inequalities. Of course, more and better evidence would make the task easier, but there is still a great deal that can be taken from the evidence as it currently stands.

To produce better evidence, a number of actions by teams on the ground would help enormously and here local government has a potentially very important role to play. Local authorities must think very seriously about evaluation and contributing to the evidence base in a way that will make it possible to do better and more effective interventions.

There are a number of important principles for evaluation. All interventions should be evaluated routinely (NICE 2007). An evaluation is not some afterthought tacked onto the end of an intervention. It is an integral part of the intervention. It is not really ethical to plan an intervention without including proper evaluation at the same time. Wherever possible when an intervention is implemented, comparisons with other groups or areas not receiving the interventions should be made. For example, in the project on a Greenwich housing estate described in the box below, 'Feeling good about where we live', comparisons will be made between the estate on which the interventions take place and another estate on which no interventions are planned. When it is not possible to collect comparative information it is still very helpful to collect data before and after the intervention. It really is not much use to collect information when the intervention is all over or is half way through.

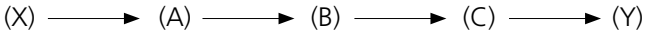
Another very important part of local evaluation is to describe as far as possible the evidence relating to linkages along the pathway from the intervention to the outcome. When an intervention is planned and implemented, there should be a clear and explicit model in the minds of the planners about why they have reason to believe that the intervention will work. There will be a theory about the ways in which the different elements in the programme connect with each other. In the Greenwich example described below the theory is that various improvements to the environment within the estate and to the homes on the estate will assist in improving the mental health of those who live there. This should be made explicit and should be used to guide evaluation (NICE 2007). The idea behind this is called 'realistic evaluation'. Realistic evaluation seeks to determine for whom an intervention works and in what circumstances (Pawson, 2001; 2006). The focus in a realistic approach is on the programme mechanisms, that is, on each part in a causal chain, in order to provide a better chance of addressing these as they occur. The following diagrammatic representations illustrate the point.

Let us assume that we introduce free entrance to gyms run by the council. Let's call that X. The idea behind this is that some change in behaviour (B) will follow from X and will lead to the outcome Y which is greater gym use.

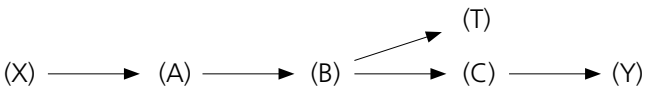


The realistic approach would start not by trying to measure the impact of X on Y by for example using a questionnaire or counting the number of people attending the gym, but would break down the all the links in the causal chain from X to Y and consider how they might work. Similarly, in the Greenwich example in the box below, the realistic approach would not initially attempt to measure directly the overall impact of interventions on the mental health of residents, but would look at any changes following the 13 different interventions proposed.

Thus:



So in simplified form changing the entrance charge (X) is based on the theory that the price determines people's behaviour. No doubt it does, but so too does the amount of time they have to go to the gym, whether they like the thought of doing exercise, whether they believe exercise will do them any good, whether the gym is in a convenient location and so on. So A in the diagram is the complex of factors which will determine the degree to which the reduction in price will lead to a change in behaviour. And of course even if the change in behaviour does take place, C in the diagram represents all those factors which will determine whether the behaviour is maintained and becomes a habit. The road to the gym is paved with many good intentions and there are all sorts of other outcomes that may arise. So in the next diagram, T is the outcome for the person who goes out and buys a new set of gym clothes and trainers but never wears them to go to the gym and never actually does any exercise.



The principle is simple, but what an evaluation must do is describe very clearly what these different steps are, seek to be clear about the reasons why the steps along the pathway may get interrupted and try to evaluate the outcome using as much information about these steps as is possible. In the Greenwich example, using the estate where no interventions are planned as a control enables the project initiators to see whether the changes might have happened anyway, even without the interventions.

This sort of information is absolutely vital in order to develop and improve the evidence base and so do better interventions. Some of this sort of information is readily available and NICE makes good use of it. But more of this would provide an even better basis on which to proceed. Local government is ideally placed to collect it.

Making a difference to health inequalities and improving population health can be done on the basis of evidence. Much can be done now and the implementation of NICE public health guidance is one important way that local authorities can do this. But looking further into the future, more and better data collected by local authorities would undoubtedly be hugely beneficial.

Feeling good about where we live: what can a local council contribute?

'Feeling Good About Where We Live' is an initiative by the London Borough of Greenwich. It focuses on improving people's environment and living space with the aim of improved mental health among residents.

This three-year project, developed by Greenwich Council and PCT, focuses on two estates in deprived areas of Greenwich. One is a control where no interventions will take place. Both are in the bottom 10 per cent of the index of multiple deprivation. The first half of the project – 18 months – will involve consulting residents and implementing changes. People will then be questioned six and 18 months later about the changes. After that the project will assess any improvements to residents' mental health.

The project has six main themes:

- home comfort
- peace and quiet
- room to move
- feeling safe
- what's on
- liking where you live.

It also has a set of 13 related factors in the physical environment that can be used as predictors of poor mental health.

For the past two years, Greenwich PCT has funded the engineering and consultancy firm Arup to explore what small-scale physical and social interventions might make a difference. For example, there is evidence that wildflower planting can help people to enjoy their immediate surroundings more. This is one of 13 factors identified by the project.

Other interventions may focus on specific dwellings, for example, installing bunk or desk spaces in bedrooms so that young people have a space to study at home. There will also be interventions designed to get people together, such as events on the estate, to help meet some of the social aims of the project.

Significantly, the project intends to work within mainstream budgets and adjust them where necessary. The department of neighbourhood services at Greenwich Council is keen to test different uses of mainstream resources to see if this makes a difference to people's sense of well-being.

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4 The changing public health workforce

Alan Maryon-Davis
President of the Faculty of Public Health
Honorary Professor of Public Health, King's College London

A decent home, clean water, good nutrition, a proper education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship – these are the fundamentals for improving public health and well-being and reducing inequalities. And there's no question that most of the key levers are with council services.

Public health specialists know this full well. They are especially skilled at looking at the 'bigger picture' and acting as catalysts to promote healthy lifestyles and environments, prevent disease, protect and improve general health, as well as improving healthcare services. Much of their work is focused 'upstream' – the much-quoted analogy of helping to prevent people from being thrown into the river in the first place, rather than the more traditional healthcare role of fishing them out downstream, coughing and spluttering. In other words, they are usually more concerned with tackling the causes than the consequences of ill-health – especially the social determinants, the causes of the causes

Specialist public health professionals, directors of public health (DsPH) and their teams, who since the great schism of 1974 have been mostly based in the local NHS health authority (latterly the PCT), know full well that they can never hope to achieve lasting reductions in health inequalities without effective partnership with local government. In recent years, the breadth of the public health role has been recognised in that accreditation as a specialist is open to applicants from a wide range of backgrounds, medical and non-medical, who wish to become a consultant in public health, a director of public health (DPH) or other consultant-level public health professional. We are now beginning to see a number of directors of public health (DsPH) being appointed with a background largely in local government, bringing different experience and skills to the mix.

Even within the clinical health professions, there is an increasing understanding of the social determinants of health and the need to work 'upstream'. For example, a nurse who trained within a traditional medical model of health 20 years ago, working on hospital wards, may now be part of a supportive public health team, working to reduce health inequalities through a community empowerment approach – carrying out health needs assessments for maternity or alcohol services, evaluating a domestic abuse project, talking to community pharmacists about sexual health services for young people or piloting work on community health trainers. And all this will involve close relationships with colleagues in local government or, increasingly, employment by a local authority itself.

Now, thanks to recent central policy, over 80 per cent of DsPH are joint appointments between the NHS and local authorities, acting as shared expert, catalyst and critical friend. The joint DPH should be well placed to enhance well-being and tackle inequalities through joint health promotion initiatives, community projects and programmes, joint strategic needs assessments, the local strategic plan and local area agreement. The DPH is also a key resource for the council's overview and scrutiny function. And a raft of targets and performance indicators shared jointly between the NHS and local authority should mean that effective integration of public health professionals and council officers is an absolute must-have. We're all in this together.

But how well is this fusion working? Are we seeing a true marriage of hearts and minds?

My impression is that, although it's sometimes less than optimal, there's a wealth of vibrant joint working between public health and council services, and in many places really well integrated joint teams. This publication gives lots of examples of good practice, and many more can be found on your council's and local PCT's websites. The great majority of such initiatives are steered by integrated joint NHS/local authority teams, usually with voluntary sector and commercial partners, and often driven by the DPH.

What do public health professionals bring to the party? Demographic and epidemiological data to map, focus and evaluate various interventions. Advice on the evidence base: what works? what's value for money? Shaping a social marketing campaign or health fair. Acting as the public face or media spokesperson. Providing leadership to drive the whole initiative.

Public health specialists are trained in all these skills and many others. They are drawn from a wide range of disciplines and professional backgrounds – health and

non-health. As well as driving health improvement, they are also experts in health protection (working closely with environmental health practitioners and emergency planners) and service quality (working alongside commissioners and providers in local government as well as healthcare).

So your local DPH, with his or her team, is an incredibly versatile resource which I hope is being put to best use in your area as leader, advisor, catalyst and, at times, critical friend. Sadly, for various reasons, this is not so everywhere. I have come across quite a few councils where the links with their local DPH are minimal and the potential gains unrealised.

Why is this? A common reason is a lack of awareness among council officers and elected members regarding the skills and expertise public health professionals have, or a lack of understanding as to how these attributes can help the council deliver its strategies and services. These can be remedied by a more assertive 'selling job' by the DPH – but also by a more positive and welcoming attitude on the part of the council.

On the local authority side, the DPH should be afforded sufficient status in the management structure, at chief officer level, reporting directly to the chief executive – and where appropriate given responsibility for key services such as the information hub, special housing or environmental health. The NHS side too should fully recognise the potential benefits and, together with the local authority, provide the DPH with a properly resourced, well-trained team with enough capacity to take on the extra work arising from a much wider span of responsibility.

There will be a need for public health specialists for as long as there is a need to promote and protect the health of the people, prevent avoidable health problems and reduce health inequalities. The nature of practice has changed to adapt to new public health challenges. Where once the main threats were from infectious diseases and malnutrition, our agenda is now dominated by long-term conditions and obesity. But the pendulum swings back and forth. The bugs are biting back – with pandemic flu, E coli 157, multiple-drug-resistant TB, MRSA, C diff and many more. And sustainability and carbon-reduction are increasingly becoming major public health issues.

This means that we need all the allies and support we can get within local government. Many of the larger local authorities, such as Birmingham and Manchester, now employ their own health teams who work closely with the joint Director of Public Health and the public health specialists in the PCT. There are also some interesting secondments and appointments of public health specialists to various local authority departments, such as planning and transport, to help these departments see their core services through a 'health lens'. My own team in the London Borough of Southwark comprised a vibrant mix of local authority and PCT staff, and gained much energy from those relationships. I would like to see this trend continuing and being built upon.

We need to develop an approach that recognises that more or less the whole of the public sector workforce are potential contributors to public health. Chapter 5 contains an account of a course run by the London Borough of Greenwich called 'Health: Everyone's Business' which has been attended by a wide range of council staff from directors to those on the 'frontline'. When I gave a talk to the course members a while ago I was most impressed by the sheer variety of 'non-health' people attending – almost every council service was represented. This is the message we need to send to the whole of local government – health is everyone's business – although I would expect them to embrace this idea much more readily than many of my healthcare colleagues, still locked in the 'medical model' of health.

Every local authority chief executive and every director of a council department should regard themselves as having as much responsibility for the health of the population they serve as they do for their own named service area, be it transport, environmental services, education, urban or rural planning or sports and cultural services.

I know that there are many in local government who already have this understanding and that it is beginning to inform policy-making and operational planning across the public sector. For example, within the crime and disorder partnerships that now exist in each area, you are just as likely to find a public health specialist as a borough police commander or a town centre manager from the local authority, all of whom are beginning to see that reducing drug- and alcohol-related crime, preventing the injuries and ill-health caused by problem drinking, and town planning, are inextricably linked.

And it should be no surprise if a head of planning initiates health impact assessments before all major planning decisions, since planning decisions are also, ultimately, health decisions. We have largely gone beyond the days when planning for new towns assumed that car use would be the norm. But we have not reached the achievements of some of the northern European countries which have incentivised cycling and walking, through sophisticated planning, to an admirable degree. If we are to change what the Foresight Report on obesity calls our obesogenic environment, this is the kind of thinking we need. To achieve it, we have to foster the increasing mutual

understanding of the public health and local government roles.

I would also like to see local authorities making much greater use of the specialist skills of public health colleagues. For example, epidemiology is the cornerstone of public health practice. It is the study of health and disease in populations, including the causes or determinants, taking account of underlying social and demographic factors. Public health specialists analyse and interpret this information, and use it to help match services to need, and improve effectiveness, efficiency and equity. So it's about understanding what impacts on people's health and well-being, and profiling those who need services, those who use them, and, importantly, those who miss out. Epidemiological approaches can also tell us what works and what doesn't.

All of these skills are incredibly useful in helping local authorities understand the health impact of their services and, indeed, in helping communities understand the main influences on their health and well-being. I think it is fair to say that drawing on this kind of intelligence to help shape effective interventions has not been one of the strengths of local government. On the other hand, it is also probably fair to say that, until recently, engagement with communities on their own terrain and in their own terms has been more of a focus of development for local government than for the NHS. What huge 'added value' there could be in tackling health inequalities if we married the two great strengths of evidence-based practice and community engagement.

Joint working with public health has been most successful where there are real enthusiasts at senior level, high-profile champions and some quick wins. An attention-grabbing campaign, an award-winning initiative, an empowered community, better targeted services, achieved performance, improved health outcomes – these are the triumphs that win hearts and minds.

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Section 2 – Taking a corporate approach

Introduction

It is clear from the material in the preceding section that by taking an integrated, 'joined up' approach to health improvement and reducing health inequalities across the whole of a local authority, and, indeed in collaboration with other sectors in the area. A council can hope to make inroads into this 'wicked issue'. In this chapter, two key figures from very different local authority areas, the London Borough of Greenwich and North East Lincolnshire, look at the way in which their local authority has taken a corporate approach to health. John Nawrockyi is the director of adults and older people's services in Greenwich, a role which requires close working with the PCT and the DPH. But the council has not been content with strengthening the relationship between the NHS and social services. It has also put resources and energy into developing its much broader role on the wider determinants of health. For this purpose, it has developed a pioneering course, 'Health: Everyone's Business', referred to by Professor Maryon-Davis in his article in the previous section, which is now being emulated by other local authorities across the country.

Dr Tony Hill is the executive director of public health for North East Lincolnshire, jointly appointed by the council and North East Lincolnshire Care Trust Plus. As a Spearhead area the council and the PCT have strived to make an impact on deep rooted and persistent inequalities in health. In response to these challenges Tony has taken the bold and radical step of transferring the whole of the PCT's public health directorate on secondment to the council – an indication of the importance he attributes to the role of local government in health. While acknowledging that the impact of this move has yet to be seen in public health and performance data, Tony describes what he views as the emerging added value to public health of these partnership arrangements.

Dr Hill refers in passing to the workload of DsPH and this is an emerging theme across the country. Joint DsPH are really being expected to do two jobs, as a senior director in two organisations with very different cultures, the NHS and local government. Indeed, it might be said that they have a third job – that of fostering the local partnerships on health issues that are now considered essential to an effective approach to tackling health and health inequalities issues. Many DsPH spend a considerable portion of their time on supporting the health and well-being board of their LSP and it is noticeable how often the role of the DPH is regarded as pivotal, indeed essential.

Some local authorities, particularly the larger metropolitan boroughs, have health units based within the council, which can support the DPH in his role. But many do not, relying perhaps on one member of staff, for which this is sometimes only part of their job description, to support the DPH. Many have relied on the PCT's public health directorate to provide this support, but, as Dr Hill points out, they have other work (such as their technical work on health protection and epidemiology) and may not, in fact, be best placed to support health work within the local authority. When we read throughout this publication of what the DPH role ideally involves, it is clear that councils and their health partners will have to think long and hard about the infrastructure they provide to support their DPH.

The 'Total Place' programme was launched in April 2009 as part of the Treasury's Operational Efficiency Programme. The programme maps how money is spent in a local area and allows all the organisations spending the money to work together to find innovative ways to improve the services and cut the costs. Birmingham, for example, spends £7.5 billion annually across all public services and, as a pioneer of the Total Place approach, it has developed projects which include redesigning services for people with mental health problems, for people who abuse drugs and alcohol, and for young people leaving the care of the local authority.

In Chapter 7, Martin Seymour, Principal Consultant for the IDeA Healthy Communities programme, considers whether collaborative working across agencies through the Total Place initiative and the associated 'Parallel Places' could lead to improved health improvement outcomes alongside efficiency and effectiveness gains. Many of the thematic priorities being examined under the heading of Total Place have the potential to improve health directly; all will address upstream causes – the social determinants of health. Seymour discusses the opportunities to place health improvement outcomes alongside efficiency and effectiveness gains and to give greater recognition to

both the business and the social case for preventative action. He cautions however, that evidence from past partnership initiatives, including evaluations of local strategic partnerships, points to difficulties and tensions in collaboration. He suggests we cannot make assumptions about the health benefits of the Total Place initiative, but will have to make a conscious and explicit commitment and effort to achieve them.

5 Greenwich – health is everybody's business

John Nawrockyi
Director of Adults and Older People's Services,
London Borough of Greenwich

Greenwich Council has long recognised the importance of the local authority's role in improving health and tackling health inequalities. This is reflected by a decision to create a senior officer post of head of healthier communities and a healthier communities strategy which keeps health issues at the heart of core council services. The council has also fostered a close and effective partnership with the local PCT, NHS Greenwich. This approach resulted in Greenwich Council achieving Beacon status for reducing health inequalities in 2008/9.

The head of healthier communities takes the strategic lead for all council health improvement initiatives and ensuring that all council services are more effectively using their resources to tackle health issues. This is encapsulated in the healthier communities strategy which aims to improve health issues across all policy areas, so that the council further develops its role as an agent of health improvement. This dovetails with NHS Greenwich's health improvement plan. Also, a five year borough wide strategy 'Health: Everyone's Business - a health improvement strategy for Greenwich' had its content agreed at the health and well-being board (HWB) in October 2009.

Greenwich has developed a partnership structure that centres on the HWB and the improving health cutting inequalities group (IHCI). The HWB is a sub group of the LSP and is responsible for agreeing key priorities and monitoring progress against the health and well-being LAA targets. It is made up of lead councillors, non-executive directors of NHS Greenwich and senior managers from the council and PCT including the Head of Healthier Communities and Director of Public Health. The IHCI, which is made up of officers from the council and health partners, provides the operational support to HWB by coordinating all the cross-organisational actions.

An important element of the Healthier Communities Strategy is the development of a course for staff: Health: Everyone's Business (HEB). The thinking behind it is that decision-making staff in every council department are ideally placed to ensure that maximum positive impacts on health are considered in every policy decision.

The HEB is an introductory health improvement course that provides participants with the knowledge, skills and language to promote health within their council roles. HEB graduates then become a core group of 'health improvement champions' working in decision-making roles across council functions.

HEB is deliberately targeted at officers from all departments within the council rather than only those working in obviously health- or social care-related areas. For example participants have included officers from housing, transport, planning, chief executive's department, environmental health and regeneration. It runs for one day a month over six months, thus involves a considerable commitment in terms of resources and participants' time. The course covers public health theory and involves interactive sessions and project work, and has a strong focus on practical application. Each participant undertakes a project that explores and demonstrates the positive health impacts within the context of their role. The course covers subjects such as the wider factors which impact on health, health needs assessment, mental health and health promotion, and the role of the local authority. It benefits from input from the council's lead member for health and partners such as NHS Greenwich, the voluntary sector, Royal Mail (Workplace health), IDeA, the Faculty of Public Health, and the University of West London.

The HEB is continually evolving and each successive course is shaped by continued learning from participant's feedback. Participants and contributors are asked to give their views on what they learned, what worked well and what could be done differently. There is a final evaluation at the end of each course and an examination of the longer term impacts following the second course with another such exercise planned shortly.

So far feedback has included the need to extend the course to participants from partner organisations; that interactive sessions work best; and that adequate time has to be built in to facilitate the project work, which can be intensive.

Greenwich Council continues to develop its role as an agent of health improvement to help tackle the poor health outcomes many of its local population still experience. Ongoing challenges include: maintaining the change of culture within the organisation so that health continues to be embedded within core services; and developing greater

awareness of the implications for health amongst all council officers.

Each HEB course has built on the success of the previous one and the model is being shared, most recently via a 'taster' session with the North East Healthy Learning Network which covers all 25 local authorities in the North East. Other dissemination events have included a Beacon showcase day that focused on what has been learned from HEB and presentations at the UK Public Health Association conference and seminars for the Health Service Journal and King's Fund. There are also plans to adapt the course so that it will include participants from NHS Greenwich and other partners.

Key steps to successful delivery

- Identify a senior officer to take on lead responsibility for health within the council
- Develop a joint health improvement strategy with PCT and other health and well-being stakeholders
- Develop a strategic mechanism for monitoring progress on LAA targets covering health and well-being
- If developing a 'HEB type' course:
  - establish and maintain senior management 'sign up' to the course
  - engage and consult with local health partners to ensure their involvement in the course
  - extend eligibility to both NHS and Voluntary sector partners
  - develop a course outline with learning outcomes and core subjects to be covered to be delivered as part of the council's corporate training function.

Greenwich – practical applications from Health: Everyone's Business course

In addition to attending the sessions that make up the Health: Everyone's Business course in Greenwich, participants undertake a project to demonstrate health impacts of their own roles. These projects have resulted in positive action being taken in departments across the council to change common practice. Some examples are outlined below.

Better steps to health – Participation in the course resulted in a pilot health promotion intervention for school crossing patrols including pedometer use and a health promotion event which has become a regular feature in training these staff members.

Young homeless people – As a result of the course, the participant reviewed and amended assessment forms to change the way young people are asked about their smoking habits and whether they are registered with a GP, and to ensure the information is used proactively.

Community meals service – A course participant mapped client addresses against deprivation in order to highlight likely health inequalities, and concluded that drivers would be ideally placed to train as Community Health Promoters in addition to their existing role, which included using a screening tool to identify those with malnutrition.

Community services – By evaluating the services currently being offered within the council's 25 community centres, and mapping their locations against health inequalities, the participants identified gaps in service provision that represent opportunities to tailor health promotion to communities.

Mental health in the workplace – Course participants audited Greenwich Council's support for employees' mental health by assessing provision against the '12 steps to better mental health' model, and making recommendations on future provision.

Trading Standards (underage sale enforcement priorities) – The participant explored mortality rates relating to the range of proscribed products (alcohol, knives, tobacco, solvents and fireworks) and made recommendations about future resource allocation which took account of health impact.

Equality Impact Assessments (EIA) – The course inspired the participant to develop an analytical tool which will help managers consider the possible health impacts from the six EIA equality strands in Greenwich, thereby enabling future strategies to consider health impacts in an integrated way.

Transit (young driver and rider education project) – As part of an initiative to encourage young people to consider the consequences of their motor vehicle use, the participant was inspired by the course to make adjustments to training to emphasise issues of inclusion, self-esteem, respect and mental health generally.

Handyperson service – The participant explored the health impact of this service which is aimed at low income older and disabled people, providing a handyperson to perform 'odd jobs' in the home. The course helped highlight health inequalities across the geographical areas with the Borough and enabled the participant to better target those communities most in need.

6 North East Lincolnshire – integrating public health with local government

Tony Hill
Joint Executive Director of Public Health
North East Lincolnshire Care Trust Plus and North East Lincolnshire Council

North East Lincolnshire is a small Unitary Authority covering the towns of Grimsby, Cleethorpes and Immingham. Grimsby has a fishing heritage, with current industries ranging from food production to renewable energy and chemical industries. Cleethorpes is a seaside resort and Immingham is the largest port in the country. Health is poor with considerable deprivation and long-standing and wide inequalities in a range of public health indicators. This was a major driver for these changes. Improvements in these indicators are beginning, but we expect it to take a number of years to close the gaps with national rates.

A jointly funded, jointly appointed Executive Director of Public Health post was established early in 2007, and in September of that year a unique organisation came into being, North East Lincolnshire Care Trust Plus (CTP). This is a Care Trust, where social care commissioning is delegated to the former PCT, with two additional elements – the 'Plus'. These are the delegation of children's health commissioning to the council and delegation of the CTP health improvement responsibilities to the council to sit alongside its well-being powers. In order to deliver this the entire public health directorate, around 80 whole time equivalents, is seconded to the council, although staff work back into the CTP to continue to deliver health protection services and the support needed for commissioning health and social care, such as needs assessment and effectiveness work.

This arrangement has given us the opportunity to give a substantial Public Health input in priority setting in the council. Previously the council had no health priorities. It now has just four strategic aims and one of those is 'to improve health and well-being' which includes reducing health inequalities. The other three strategic aims all support the wider determinants of health: economic development, physical regeneration, housing and community safety.

We have also been able make some specific commitments to work with some teams of colleagues in the council to give a Public Health input to their work. This is the 'added value' of our arrangement and has included support to:

- the strategic housing team to include health impacts and outcomes in their considerations by undertaking an integrated impact assessment on the East Marsh Neighbourhood Renewal Area
- regeneration, where a joint health impact assessment of the regeneration strategy has resulted in the identification of many actions which can be adapted to give added health value.

Similar work and benefits have occurred with teenage pregnancy, tobacco control and active recreation. For example, a GP physical activity referral programme, working with Leisure and Recreation and service providers, has already seen 247 referrals since 1 April 2009 with a 68 per cent retention rate at ten weeks. Last year was an excellent result; this year looks even better. Other joint working between public health staff and other council staff has seen around 2000 people begin or increase their physical activity this year.

The other 'added value' relates to existing public health programmes, which have been given a boost by being able to access council staff, resources and contacts. Our smoking quit rate is a good example of this, where following several years of failure to meet targets, working with colleagues has contributed to a position where quits are at 160 per cent of target, the success rate for those using the service is 61 per cent compared with the national average of 50 per cent and quits are significantly higher in areas of deprivation.

As someone who has worked very closely with local authorities over several decades, this has proved to be a challenging experience. The culture shock has been huge. Although I thought I understood the role and influence of elected members, I discovered that I didn't really! Their involvement and the way in which the organisation runs is so completely different from the NHS that a whole new approach to using influencing skills is required. Approaches that worked well from outside the organisation need to be reconsidered, not just refined. Informal work seems to be critical.

The second huge challenge for a joint DPH is workload. The DPH role is extensive anyway, with a range of expert

functions, a substantial input into partnership working, a big set of responsibilities as a senior clinician and often additional corporate responsibilities, such as infection control. Carrying two corporate workloads adds to this, with many meetings not directly related to the professional role. I have experienced a great deal of understanding from my Chief Executives, although not always from others. The dilemma is that it is not always possible to anticipate when an opportunity for a public health input will arise. High quality, flexible senior public health colleagues are essential to success here.

A potential for difficulty arises because of the need to maintain organisational confidentiality while at the same time being expected to act as a conduit between two organisations. Discretion, transparency and occasionally stepping backwards are required here. The need for formal mechanisms can't be stressed too much but the opportunity for delicately suggesting an informal word between colleagues is not to be missed.

A final word of caution relates to the time it takes for these major changes to be understood and embedded. We still find people who don't understand the changes and many who have not been able to think through the implications of our new ways of working. This is despite opportunities to find out and explore what we are trying to do. The danger is that health and well-being improvement opportunities are being missed.

Joint Public Health arrangements can take many forms. What is right in one place will not necessarily help elsewhere but the issues of culture, workload and achieving the best from the arrangements will be common to all.

7 Embedding health in a vision of 'Total Place'

Martin Seymour
Principal Consultant, Healthy Communities Programme
Improvement and Development Agency

In a 'whole area' approach to public services, at the heart of the 'Total Place' initiative is a drive for improved efficiency and effectiveness in the face of reduced public sector funds and increased demand for services. 'Total Place' forms part of Sir Michael Bichard's Operational Efficiency Programme (HM Treasury 2009) looking at the scope for efficiency savings in the public sector with a focus on partnership working. Bichard describes how this whole area approach "is about giving local providers the incentive to work together in new ways for the benefit of their clients and citizens – and the opportunity to tell Government how it could behave differently to make this kind of collaborative action more likely" (Leadership Centre for Local Government, 2009). Thirteen pilot programmes backed by £5 million funding will map flows of public spending in local areas under thematic priorities that range from children's health and well-being to services for older people and include minimising re-offending, tackling alcohol and drug abuse, road safety, safer, stronger, healthier neighbourhoods and housing and regeneration. The pilots will bring together agencies to identify where public money can be spent more efficiently and effectively to improve local services, with a view to identifying lessons that can be applied more widely (IDeA 2009).

The process of Total Place consists of 3 interwoven strands: 'counting', 'culture' and 'customer needs'. Commencing initially with a high level count of all public expenditure going into the locality, the counting process also includes a more focused 'deep dive' into a specific theme. Birmingham, for example, has identified £7.5 billion of public sector funding coming into the area and the spend in Central Bedfordshire and Luton equates to £6,853 per person. The 'culture process' looks at the way existing cultures, the way we do things at the moment, actually help or hinders the process, while the insights of the 'customer needs' strand helps pilot areas better understand their citizens' needs and identify opportunities for collaboration between agencies on service redesign and use of resources.

Collaboration is a key requirement of Total Place, with the public, voluntary and business sectors working together to address specific issues within a locality, identifying and eliminating duplication and delivering interventions to reduce long- term service costs. Such collaboration also offers opportunities for achieving better health improvement outcomes, including addressing health inequalities. Many of the pilots specifically refer to health improvement objectives, such as Croydon's focus on children's health and Leicestershire and Leicester City's on drugs and alcohol. By following the flow of money across service providers, Bradford has identified the complexity of provision for young people leaving care and is introducing a single point of access for care leavers, where they can have both their practical and psychological support needs met quickly in one place. In designing a more effective approach to services they are both introducing efficiencies and providing an integrated pathway for each young person.

Other pilot themes have the potential to impact further upstream on the social determinants, or the 'causes of the causes' of poor health: on housing; on improving work and skills; on crime and anti-social behaviour; on building safer, stronger neighbourhoods and on the 'lived in' environment. Beyond the Total Place pilots are an increasing number of Parallel Places, areas progressing with similar methodology and applying it to specific issues within their locality. Some are funded by regional improvement and efficiency partnerships (RIEPs), others are self funding. All have increased flexibility to determine the themes they want to look at in depth, the scale of the work they wish to undertake and the way in which they want to progress it. Suffolk was a pre-Total Place collaboration, and rather than starting from an analysis of the public sector spend, focused initially on building a foundation for effective relationships and trust between partners. The development of parallel places could be seen as a natural progression for partnership working between agencies. Through the application of 'Total Place' methodology they can seize the opportunity to place health improvement outcomes alongside efficiency and effectiveness gains and to give greater recognition across partners of both the business and the social case for health improvement.

The extent to which Total Place will address health inequalities has yet to be seen. While we might expect its focus and style of collaborative working to lead to health improvement outcomes, evidence of past experience of collaborative working suggests this may not follow. Smith et al (2009) report on a systematic review of partnership working for health improvement and caution that the

contribution of partnership working to improving health is far from clear. The authors assert that persistent policy support for the concept is largely faith based. Wanless (2004) referred to an absence of evidence on the effectiveness of multi-sectoral partnership working and called for an evaluation of the way in which the NHS and local authorities were required to work in partnership to achieve public health outcomes.

Marks (2007), reporting on LSPs, identifies a range of process issues and tensions that impact on what she refers to as the 'doing' of partnerships and asserts that 'such tensions undermine the capacity to work across the LSP and maximise its impact on narrowing the health gap' (p145). Process barriers are also acknowledged by other authors including for example Hamer and Smithies (2002) and Perkins (2009) who identify tensions in agreeing joint priorities, targets and performance management; working across boundaries; governance and accountability; community involvement; member involvement ;and how to use flexibilities such as pooled budgets, joint posts and integrated services. These difficulties and tensions suggest that we cannot make assumptions about the health benefits of the Total Place initiative, but will have to make a conscious and explicit commitment and effort to achieve them.

Smith, (2009), reporting on a round table event hosted by the Guardian noted the need for a different way of working and a cultural change within the public sector and its approach to partnership working. Commenting on the lessons learnt so far, Croydon, one of the pilot areas, indicates that a change of culture may be taking place: it reports a shift of thinking from top-down implementation to bottom-up ideas generation. And it reports a wider recognition of the need to shift from late stage intervention to invest in upstream preventative measures to tackle health, crime and disorder, and worklessness. The discussion however also noted difficulties in identifying the efficiency value of early interventions; and highlighted other challenges to collaborative working including the barriers created by professional boundaries, the complexities of empowering citizens, and the perennial issue of joint accountability and aligning funding. If 'organisational gaming' and the question of which agency will lose and which will gain still exists, then Total Place might not be so different after all. If these issues can be avoided - and the economic imperative may just be the catalyst for doing so - then Total Place could offer real opportunity for addressing the social determinants of health.

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8 Local Government – what does it mean for the frontline?

The centrality of local government in tackling the social determinants of health and reducing health inequalities and the challenges local authorities must meet have been set out in no uncertain terms in the previous chapters. This chapter looks in more detail at some of the different local authority functions and how they impact on health. These are:

- children's services
- adult social care
- planning and transport
- housing
- environmental services
- culture and sport
- work, worklessness and the local economy.

The case studies within this chapter provide real-life illustrations of how a range of local authorities are using these functions to mitigate some of the negative aspects of the social determinants of health, and reduce inequalities between areas and groups. The discussion of different functions below is not intended to be comprehensive, but to give an indication of the variety and scope of the potential for action and of the interventions currently taking place.

Children's services

One of the key outcomes for children and young people to emerge from the policy changes following the first Laming report on the death of Victoria Climbié is the 'Every child matters' outcome 'Stay Healthy'. This puts improving health outcomes for children and young people at the heart of local authority services. Local authority children's services understand that health outcomes are very different in different parts of their geographical areas and their strategic and operational planning aims to impact on these inequalities. Front-line staff know many factors can impact on children and their families. These include aspects such as a poor start in life, parents who have experienced problems of stress, social exclusion, unemployment, addiction and poverty themselves, lack of ambition and expectation, poor housing, and difficulties in accessing services due to poor transportation links.

Children's services are crucial, not only for the well-being and safety of children and young people, but they also contribute to the economic well-being of the area, the physical environment, the sports and cultural opportunities available. They have a leadership role in the development and implementation of integrated early intervention and preventative support, as well as targeted support, through the implementation of the common assessment framework and lead professional role, pulling together different agencies for the early identification of needs and provision to meet those needs. Fundamental in children's services is providing top-quality opportunities for children and young people who are looked after by the local authority, often some of the most vulnerable and with the worst health outcomes.

Children's services workers provide some of the most crucial services which contribute to reducing health inequalities. They plan, manage and deliver services in Sure Start Centres to children aged up to five and their parents. Some examples of Sure Start activities include regular facilitated days out for families who have struggled with domestic violence, drug and alcohol misuse and family breakdown. This creates an opportunity for parents and children to have time together doing fun things in a safe and managed environment. Other activities include a healthy eating/ cookery club for parents, culminating in a social event for the children where parents do all the catering.

Children's centres and CAB in Halton – tackling poverty

Halton's children's centres have a contract with Halton Citizens' Advice Bureau to provide services to parents with young children. Families with young children receive fast-track support, and are usually contacted within three hours of referral. Parents are allocated a named adviser to guarantee continuity of service, and an award winning secure online referral system is used to track parents through the service. A home visit is offered to new parents referred to the service. This enables advisers to carry out a financial health check in addition to addressing any specific issues. CAB and children's centre staff work very closely together, attend joint meetings, and address families' needs in partnership where required.

In a period of nine months the service secured £179,000 in new benefits for parents, and helped manage £223,000 of debts.

Children's centres support the most vulnerable and youngest parents not only in bringing up their child but also to develop themselves through providing access to training and employment advice and opportunities and thereby improving their quality of life and standard of living overall.

Children's centres, health and housing in London

In **Tower Hamlets**, the local authority housing and children's services and the PCT have jointly funded a 'temporary accommodation outreach team' working out of local children's centres. The team identifies any issues a family in temporary accommodation might have, provides support with housing issues and signposts to children's centres and all other local services.

Using children's centre capital funding, **Harrow's** early years service has refurbished the communal area of a temporary accommodation family hostel, bringing early years services direct to marginalised families.

Enfield's Temporary Accommodation Play Project (ETAPP) is funded by children's services to ensure that homeless children can access appropriate play and activity services, and that parents receive support, advice and information that help them.

We know that educational outcomes and consequent further education and employment opportunities, leading to enhanced quality of life are among the most important determinants of health in later life. Local authorities are committed to school improvement and work with partners in central government and with other agencies to drive up improvement and educational outcomes for children.

Extended schools services provide a core offer of activities, advice and opportunities including healthy school meals and healthy vending strategies as well as travel-to-school schemes (encouraging safe walking and cycling) and active play projects. The new Extended Services Disadvantage Subsidy from central government is intended to support those children and families who are most disadvantaged, particularly those living in poverty or in the looked after system. The 'Healthy Schools' initiative is a key part of addressing health issues, with healthy schools teams providing consultancy to schools on key areas such as substance misuse, healthy lifestyles, and relationships.

Youth on Health in Leeds

In Leeds, the local healthy schools team has set up Youth on Health (YOH). It is a participatory health forum that involves local young people aged 8 to 17. Every half term, each YOH group meets to discuss different health-related issues that concern and affect today's young people in a fun and creative way. They then feed ideas back into their own school council to help it become more innovative in tackling health issues at school.

Some of the ideas implemented in schools across Leeds as a result of the YOH initiative include:

- introducing a supermarket-type salad bar into the school canteen
- replacing sixth form vending machines with healthier options
- introducing fair trade goods
- free drinking water throughout school
- challenging smoking around school
- improving school councils
- introducing peer mediators.

Giving children and young people a voice is a key part of the 'whole school approach', which the National Healthy Schools Programme promotes.

Recent research from one northern city indicated that one in seven young people not in education, training or employment (NEET) over a long term died within 10 years of falling out of the system. This shocking statistic emphasises the importance of the contribution children's

services will make to the new responsibilities which are due to be transferred to local authorities in 2010 for commissioning, funding and in some cases providing educational opportunities for 16 to 19 year olds. People working with young people at risk of offending or involved in the youth criminal justice system – as well as those who have encountered difficulties in the school system – will continue to improve outcomes for young people at present not in education, employment or training.

Improving young people's life chances in Manchester

- Young people with learning difficulties and disabilities are twice as likely to be out of education, employment or training as those without.
- Young men who have been NEET for more than 6 months are three times more likely than their cohort to have depression.
- Young people with a history of mental illness, and those who misuse drugs and alcohol, are all over-represented among NEETs.

Manchester City Council decided to give a high priority to reducing the number of NEET young people because of the negative impact on the city's economic development and social cohesion and on the life chances and well-being of the individual young people. In just four years, the partnership of agencies has halved the number of young people described as NEET. This has been done through detailed geographical research of the incidence and nature of the NEET group, by recruiting a dedicated NEET co-ordinator, and developing a multi-agency NEET programme as part of their children's board. By aligning funding from a number of sources and through joint commissioning including children's services, a range of NEET engagement and aspiration-raising activities has been undertaken with young people, and specifically the five secondary schools that produce the highest number of NEET pupils.

Adult social care

Social services are currently going through a process of transformation, increasing their emphasis on preventive services and 'personalisation': that is, services which are designed around the needs of individuals. One of the results of these changes ought to be improved health and a reduction in health inequalities. The prevention and personalisation agenda, if it works as intended, should mean that:

- people are supported to live more independent lives for longer, because there is a range of housing suited to their needs
- they have access to social care before their needs turn into medical care,
- personal social care is designed around the specific needs of the most deprived groups of people
- close working between social services, other local authority services and other public services enables holistic support for the most vulnerable people, thereby increasing their overall well-being.

Most people who are entitled to free social services are hugely socially and economically disadvantaged – indeed in many cases this is what makes them eligible for social care and support. This means that if local authorities can help improve the health of users of social services they will not only be doubly helping some of their most deprived residents, but also reducing health inequalities.

Bywaters (2009) and others have identified a number of ways in which social services can address health issues while carrying out their explicit primary function of social care.

- They can reach out to and find the people in greatest need and connect them to resources and services. In a simple example, by working with housing colleagues they can identify people living with fuel poverty, not only supporting their personal care needs but also enabling them to improve their homes by insulation and heating.
- Increasingly they are doing this by making use of the skills and experience of service users themselves – for example by engaging older people as 'wayfinders' to point the way to sources of support for others in their communities. This also addresses issues of loneliness and isolation.
- They can help disabled people to remain independent by ensuring that they are aware of sources of financial and practical support, including support from voluntary sector agencies, and by enabling them to receive direct payments to commission their care. This also contributes

to their overall self-esteem and well-being, improving their living conditions and therefore their physical health.

- They can help reduce the stigma associate with mental ill-health, for example among people in ethnic minority communities. This was illustrated by the 'Mosaics of Meaning' project in Glasgow, using a series of 'community conversations' about mental illness, which included health and social care practitioners.
- They can help people avoid hospital admission by identifying and meeting their personal care needs before they turn into medical needs.

Hammersmith and Fulham: a holistic approach to well-being

The London Borough of Hammersmith and Fulham is characterised by high population density, ethnic diversity, high mobility, and a very wide range of economic circumstances. The Director of Community Services has responsibility for housing, adult social care, community safety, community liaison, regeneration and adult education, thus enabling social care to integrate approaches to a number of social determinants of health. An example of where 'place shaping' and personalisation connect in community services, which works jointly with the NHS, is the corporate Better Government programme which includes older people and younger disabled people. The function of the programme is to influence services and decisions made in the borough which may impact on older people or disabled people, and to ensure that those services and decisions have taken into account the needs, wishes and aspirates of disabled and older people. As well as changing how older and disabled people are perceived within the borough, the programme has also established a programme for over 50s, including work to prevent becoming ill and dependent on health and social services. Outcomes are measured in terms of numbers of people involved in the programme, the kind of topics and areas of work that have been engaged with the programme, and levels of satisfaction by users of services.

The new prevention agenda has set in train a number of very imaginative pilot projects, including the Department of Health's Partnerships for Older People Projects (POPPs), and Linkage Plus (interestingly funded by the Department of Work and Pensions), another initiative involving older people. These show that – with investment of time and resources – the active engagement of older people in design and delivery of social services; taking a holistic approach; and recognising the interrelatedness of people's financial, housing, social and health needs can really transform lives. The challenge will be the wider implementation of the prevention and personalisation agendas in adult social services so that they have this kind of positive impact. They should not become a means of transferring responsibility for service users' health and social well-being to service users themselves, without improving what Marmot calls "the conditions for flourishing".

Ageing well in Dorset

With the highest proportion of older people in the country, Dorset County Council has used its Partnership for Older People Project (POPP) to develop a network of sustainable local support services designed to:

- respond to the needs of the increasing number of older people
- reach and support people before they develop critical care needs
- play a leading role in helping older people to lead full and active lives.

The partnership is unusual in the extent to which it delivers preventative and health promotion services by using the capacity and skills of older people themselves. Older people are trained as wayfinders and paid to provide information, signposting and support to individuals, and as community leaders, paid to identify community needs and develop strategies to meet them.

Older people also take the lead in allocating funding to community projects. Fifteen older people have also been trained as voluntary evaluators and have undertaken the qualitative evaluation which has been an important aspect of the programme.

Planning and transport

There is an important link between how places are planned and developed and the health of the communities who live in them. This link is increasingly recognised in planning guidance and in how planners think about their work.

Each area's local development framework (LDF) – the overall delivery plan for the council - takes account of broader social, economic and environmental factors. Changes to the physical environment of communities are planned so that the physical infrastructure facilitates the conditions and the lifestyles that lead to well-being.

To achieve this, those responsible for planning within local authorities recognise that they need to work across the board in better partnership with others delivering public services. They need to understand more about the needs of communities and to make better use of the expertise of other public service specialists. In terms of health, looking at the social determinants, carrying out health impact assessments as well as environmental and sustainability assessments allows us to look at how interacting with the place affects people's well-being and health. Looking at the social determinants of health puts the focus on the community rather than simply what the land is used for.

By working with others to understand these issues, planning can help to ensure that the new development - the housing types, layout, density, and linkages to facilities, open space, employment and public services – will be more likely to improve the life chances for residents.

South Tyneside Local Strategic Partnership: linking the local development plan to wider social and economic objectives

The South Tyneside Local Development Framework (LDF) shows how the integration of physical planning with economic and social regeneration strategies can enhance the impact of both. Like many former industrial centres, South Tyneside displays many of the usual indicators of disadvantage: high crime and anti-social behaviour, poor health indicators and low educational achievement.

In tandem with the sustainable community strategy, the regeneration strategy focuses on a programme of investment – in schools, business parks, health centres, transport, housing, town centres, the riverside and the environment.

As part of the process of developing the LDF, the development team listed all the objectives in the community strategy. Using a traffic light system, it identified those with land use or other physical development implications. This included many of the interventions identified in the regeneration strategy. Consultation with the public involved a range of techniques and capacity-building activities.

The physical development continues to address economic, social and cohesion objectives, as the council believes that developments that exclude sectors of the community place themselves at an immediate disadvantage in terms of either their long-term sustainability or their ability to be accepted by the whole community. In a similar spirit, the borough's spatial vision for the area sets out the aim that "all those within the borough can access the opportunities that are available, with reliable public transport, efficient road network and above all, focusing on delivering accessibility rather than relying on mobility."

If we are planning for health we have to think about transport at the same time – a link that has not always been made in the past. Transport is a derived demand. Its primary function is in enabling access to people, goods and services.

Transport has major health impacts – through road accidents, levels of physical activity undertaken and the associated health threat from weight gain, effects on air pollution, and access to a range of services. The adverse health effects fall disproportionately on the most vulnerable groups in our societies, generally those living in poorer communities who suffer from more obesogenic environments which discourage active travel and active play, and who experience more accidents.

Increasing opportunities for non-and low carbon transport are once again an imperative for long-term survival and quality of life.

Retaining high land use densities, a greater mixture of land uses, a balance between housing and jobs, grid street networks, and the presence of separated facilities for bicycles and pedestrians have all been shown to increase walking and cycling (Active Community Environments, undated).

Those living in walkable neighbourhoods are more likely to know their neighbours, participate politically, trust others, and be socially engaged (Leyden 2005). 'Walkability' cannot be planned for without a co-ordinated approach to the built environment as a whole, bringing together housing, transport and the planning system. This is just one illustration of why an integrated approach is necessary to embed health considerations.

Accident prevention in Hampshire

Cut your speed to 30 miles an hour in villages

That was the message to motorists in Hampshire

County Council's 'Choose 30' campaign. The campaign coincided with the introduction of the first wave of 'Village 30' - an ongoing programme to reduce speed limits in all Hampshire villages to 30 mph. 43 villages across the county had their speed limits cut in autumn 2008 and a further 61 villages followed suit in the second wave of the initiative in spring 2009.

'Choose 30' included bus-back advertising, public message broadcasts on local commercial radio, and branded beer mats and sandwich bags.

Smarter travel in Sutton

Smarter Travel Sutton (STS) is London's first sustainable travel behaviour change programme. A partnership between Transport for London and the London Borough of Sutton, it was launched in September 2006 and ran until September 2009. The main aims of the programme was to reduce congestion and the environmental impact of travel by car in Sutton by boosting levels of walking, cycling and public transport use. The programme's first year focused activity on school and workplace travel plans, personal travel advice and campaigns to raise awareness of the benefits of walking, cycling and using public transport. Year two was designed to begin to change behaviour. During the second year, messages about the health benefits associated with walking and cycling were targeted at those likely to be receptive, such as gym members and the parents of school-age children. The third year of the programme sought to reinforce these messages to ensure that behavioural change is maintained. It also included planning to 'mainstream' the initiative within the council.

By the second anniversary of the programme, bus use and cycling levels had grown and there had been a significant reduction in the use of the car for travel to school.

Housing

Local authorities have always had links with housing and, until the 1980s were major builders of social housing. The 'Right to Buy' initiative and the various restrictions introduced at the same time on local authority investment of capital receipts from the sale of council houses, meant the sale of nearly two million homes from the social housing stock and their house building and maintenance programmes almost ground to a halt. Their previous role in the supply of social housing has, to a great extent, now been taken over by housing associations. But a shrinking social housing sector no longer provides housing for a broad cross section of the community and has become characterised by deprivation and social exclusion. Housing is worst at the poorest end of the private rented sector, so there is overwhelming pressure on social housing. In England in 2008 there were 1,770,116 households on waiting lists – 8.2 per cent of total households in the country. In Newham it is 30 per cent of households, in Sheffield it is 40 per cent. The overcrowding problem is worsening and is most acute in central London, with more than 60 per cent of children in the borough of Tower Hamlets living in overcrowded conditions. Under-investment in social housing has been recognised as a major problem and local authorities are now being given greater freedoms to begin building programmes, although these are very small indeed compared to the need and the level of overcrowding.

As with most of the social determinants of health, the quality of people's homes is strongly related to income. Minimising the adverse affects of poor housing remains a major challenge for local government and other agencies. In the most obvious way, damp, cold and overcrowded conditions can lead directly to physical illness. But there is also increasing evidence that poor housing conditions can also seriously affect people's mental health and sense of well-being. The British Medical Association (BMA) has concluded that multiple housing deprivation appears to pose a health risk that is of the same magnitude as smoking. And the housing charity Shelter has found links between overcrowded family housing and depression, anxiety, sleep problems and strained relationships.

Despite the diminution of their role as landlords, local authorities retain a number of important recently-strengthened strategic roles in relation to housing. As part of the sustainable community strategy for their area, they develop local housing strategies. Housing strategies are now more closely linked to environmental and transport planning and to a general approach to the 'liveability' of an area, and are often informed by health impact assessments. In theory, this involves assessing needs, determining local

priorities and planning how the need for good quality affordable housing can be met. In practice, the statistics quoted above indicate that local authorities' housing strategies are not currently backed up by the resources and powers to address needs. Nonetheless, local government's strategic role in housing could be an essential tool in shaping the places in which people live.

Local authorities also have a number of other strategies and duties in place to provide a framework for their housing activities. These include their homelessness strategies - which have done much to reduce and mitigate the effects of homelessness, especially on children; their duty to provide accommodation for certain categories of homeless people; and their strategies in relation to ensuring housing provision for vulnerable people, including those entitled to social services. They also have a general duty to ensure that all homes are fit and safe to live in. This duty is most exercised in relation to the private rented sector, especially to houses in multiple occupation, which tend to have the lowest fitness standards and the greatest overcrowding.

The role of housing becomes pivotal where services to an individual with complex long-term needs are involved. People with health problems are disproportionately like to occupy the least health-promoting segments of the housing stock, a factor that is likely to exacerbate their health problems. People with mental health problems are disproportionately represented among those who are homeless.

Tackling overcrowding in Tower Hamlets

The London Borough of Tower Hamlets (LBTH) is one of the worst areas in the country for overcrowded housing with one of the highest rates of tuberculosis. There are high rates of overcrowding among lone parents and large households, and in the black and minority ethnic (BME) community. One of the strands of the council's housing strategy is to increase the overall supply of housing, including affordable family housing. It plans to do this by:

- an initial pilot to build 61 units of family-sized housing with a preferred development partner on small plots of council land. This will increase as more sites are identified.
- new council housing – the council plans to start its own house building programme to build 17 units, housing 86 people over five sites on three LBTH estates.
- buying back ex-council three-bed plus 'right-to-buy' properties – around 100 are planned.
- increasing housing supply by at least 9,000 units by 2012.
- tackling under-occupation through incentivisation and a package of support to increase social housing stock.
- promoting low cost home ownership products to overcrowded households.
- re-housing 19 Gypsy and Traveller families and seeking additional pitches on a new site.

Some of the most effective support by local authorities includes what are called 'low level interventions', such as handyperson schemes to help older people with DIY tasks and gardening. Tasks which may seem small are often what can make or break someone's ability to go on living in their own home. It is important that government and councils recognise the significant difference that this work can make and finds means to invest in it. Work on housing strategy, low-level interventions and general liveability is an area which provides great scope for partnerships, for example with PCTs, housing associations and other voluntary sector organisations. A strategic, multi-faceted approach is needed and there is evidence that such an approach can produce returns in the numbers of people living safely and well at home, and in reduced hospital stays.

Environmental services

Environmental health is one of the most longstanding and obvious local government functions with a health impact. Nowadays local authorities' environmental services include not only environmental health but also street services, such as cleaning and litter collection, waste collection and recycling, green space management, air quality, and issues arising from climate change. In fact, they cover a significant part of what we now class under the headings of sustainability and quality of life.

Waste and recycling services are one of the most visible services that councils run. As well as simply collecting the bins, councils carry out an enormous amount of work to reduce waste, recycle, and encourage others to recycle and manage waste sustainably.

Waste management in Preston

Preston City Council works with multiple-occupancy buildings to tackle waste generated by the residents of such properties. The overall aim is to provide an alternating weekly material recycling and refuse collection service to all multiple-occupancy buildings throughout the city by focusing on the needs of each individual property and providing individual solutions. Through site visits and discussions with residents, wardens, management companies and developers, the council makes changes that take into account residents' capabilities, space available, building layout and any other operational considerations.

Solutions include recycling sites incorporating communal, lockable bins; communal 240 litre wheeled bins or blue boxes stored in convenient council-agreed locations; and recycling bins labelled to meet specific language needs, for example in Polish and Chinese.

Clean air is a basic requirement of life. Air pollution caused by human activities can have adverse impacts on our health, our physical enjoyment and aesthetic appreciation of our surroundings, the health of the living environment, and the integrity and appearance of materials and the built environment. As such, the work of local government in monitoring and improving air quality is essential to health and well-being. Local authorities are required to draw up plans to show how they are working towards the national air quality objectives. They have to review and assess air quality within their boundaries and designate air quality management areas (AQMAs) and draw up action plans where air quality is poor and action is needed.

Community Airwatch in Sefton

Since 1996 Sefton Metropolitan Borough Council has operated 'community airwatch', a programme in which residents are supplied with diffusion tubes to monitor nitrogen dioxide levels at their properties. Hands-on activities are used to promote the air quality message – for example, testing exhaust emissions of councillors' cars. The air quality service works in partnership with the PCT to disseminate air quality messages and basic health advice to local media, schools, GPs, respiratory health nurses and councillors. The council has also worked closely with Liverpool University, in particular the Centre for Intelligent Measurement Systems.

Councils recognise that although they now play a significant role in improving air quality, there is still a need for much greater integration with transport policy and planning, both local and nationally. Only through such integration can they hope to make a positive contribution to the even greater issue of climate change.

Climate change will have significant health and health equality implications. In the UK, the positive health impacts of climate change, such as a reduction in cold-related deaths, are likely to be outweighed by negative impacts such as an increase in heat-related deaths, increased cases of skin cancer and cataracts, injuries and infectious diseases caused by flooding, anxiety and depression from physical and economic insecurity and increased respiratory disease, insect-borne disease and food poisoning. Poorer social groups are likely to be more exposed to these risks and suffer more serious health impacts as a result.

The 2006 Local Government White Paper, *Strong and Prosperous Communities*, highlighted the importance of climate change as an issue that local authorities should focus on. As well as tackling air quality in the general environment, councils are expected to sign the Nottingham Declaration on Climate Change and commit to action to reduce the council's own emissions. In addition, councils can influence emissions reductions more generally through their own local procurement and operations.

Middlesbrough Council – tackling climate change

Middlesbrough Council is a Beacon Council for tackling climate change, in recognition of the way it works with partners in all parts of the community to mitigate and reduce the impacts of climate change. Middlesbrough's climate change community action plan provides a clear, documented vision for a low-carbon and well-adapted

area and this commitment is mirrored within key council strategies. The council is achieving an annual 1 per cent reduction in CO_2 emissions and its approach has been adopted by partners in the Tees Valley. Middlesbrough has made a priority of engaging with householders and communities and has taken steps to protect communities most at risk from the impacts of climate change, including the 'heatwave' plan for vulnerable elderly people.

The environmental aspects of sustainable community strategies developed by local authorities and their partners are now likely to include provision for increased 'walkability' and access to green space, allotments, city farms and community gardens; provision to tackle environmental inequalities such as inequalities in access to fresh food and air quality; improvements in waste disposal and energy management; and action to mitigate climate change.

All of the above reflect the social determinants of health and the concentric circles of widening health impact

Culture and sport

As individuals we probably all understand the health benefits of culture and sport. When we watch our children at play rather than sitting in front of the TV or computer; when we come to the end of an exhilarating game of squash; when the day's stress dissipates at the end of a good play or a night at the comedy club; when the doctor tells us our blood pressure is too high and we realise we need to walk and exercise more.

Culture and sport not only alleviate both physical and mental health problems but they are major contributors to the prevention agenda. Getting and keeping people fit and healthy has huge 'upstream' benefits particularly for an increasingly older community.

"The scientific evidence is compelling. Physical activity not only contributes to well-being, but is also essential for good health. People who are physically active reduce their risk of developing major chronic diseases by up to 50 per cent, and the risk of premature death by about 20-30 per cent".

(Chief Medical Officer, Department of Health, 2004)

Evidence from the 2005/06 Active People Survey shows that just over half of the population, 20.6 million people, do not participate in sport and active recreation at all – a matter of concern in light of the obesity epidemic and the need to engage in physical activity to reduce heart attacks, stroke and other life- and quality-of-life threatening conditions. Regular involvement in sport and physical activity also helps to create a healthier workforce.

Many local authorities have now established sport and physical activity networks or alliances. These will be important partners in ensuring that the delivery of sport and physical activity can be coordinated locally, particularly for those areas which have included objectives under National Indicator 8 (adult participation in sport) in their LAA. Many councils like Wigan are being commissioned by the PCT to help tackle obesity and improve physical activity.

Get in Shape in Wigan

SHAPE (Sport, Health And Physical Education) is the name of Wigan Borough's five year action plan to get local residents involved in regular physical activity or sport. The plan was developed in partnership with Wigan Council, Ashton Leigh and Wigan Primary Care Trust, the Wigan Borough Sports Council, Wigan Leisure and Culture Trust and other partners in the private and voluntary sectors. Because SHAPE reflects the contribution of partner organisations, programmes will run across a broad range of organisations and will

affect many aspects of peoples' lives. For example, future planning and regeneration will focus on improving the built environment and leisure facilities, with cycle lanes, better maintained parks and new sporting facilities. Some of the programmes include:

- **Steps to Health** – physical activity referral scheme working in partnership with local Health Services.
- **Next Steps** – encouraging sedentary people to become more active.
- **Stepping Out** – working with Wigan Partnerships for Older People Project, aimed at providing older people with opportunities to increase physical activity.
- **Al Fresco** – using the great outdoors to encourage all ages and abilities to become more physically active. Projects include, Dark Horse, orienteering, Tai Chi, golf and bowling sessions.
- **Food and Physical Activity** – working with SureStart and the PCT, the project aims to provide healthy eating and physical activity opportunities for parents and carers and 0-5 year olds.
- **Bridge Builders** – working with mental health services and support agencies to raise awareness and increase participation among mental health service users.
- **Let's Get Active** – to provide physical activity and leisure opportunities for adults who have a learning disability.
- **Well@Work** – improving health and well-being in the workplace.
- **On Yer Bike** – working with cycle projects and the PCT to help adults get back into cycling in a safe, fun and healthy way.

Participation in sport, physical activity and art can also have a beneficial effect on mental health, and relate to an improved sense of well-being and self-esteem. There are many examples of this, from the use of music to help people with dementia to the use of local history to engage individuals and communities. Disability sport has also grown significantly up to Olympic recognition including the Special Olympics for people with learning difficulties.

Bronchial boogie beats asthma in Oldham

In a partnership between Oldham's NHS and council music service, young people of seven to eleven with asthma meet weekly for wind instrument lessons, breathing exercises, games and a nurse-led asthma clinic. After 4 years, the award-winning project has shown significant improvements in young people's respiratory health (and musical ability)!

Bronchial Boogie Clubs meet weekly. When the children arrive they are given a drink of fruit juice and a small snack, usually fruit. A half-hour wind instrument lesson which includes breathing exercises and games is followed by a half-hour meeting with the nurses when the children's respiratory health is monitored and recorded, problems addressed and health education provided through quizzes and games. Results show a significant improvement in respiratory health:

- a 70 per cent decrease in night symptoms
- a 58 per cent decrease in day symptoms
- symptoms experienced during exercise decreased by 54 per cent.

Once in hospital or care, culture and sport can also play their part. Studies have shown that participation in arts activities, or being placed in a well-designed environment, can reduced stress levels, improve mood, create distraction from medical problems, lead to reduction in medication and aid quicker recovery.

Simple steps to improving well-being: potential for local government leisure, sport and cultural services

The Foresight report on mental capital and well-being has developed a simple concept based on the 'five a day' principle for eating fruit and vegetables. The report concluded that five simple steps incorporated into daily life can fortify mental health and can contribute to a more productive and fulfilling life:

Connect
Developing relationships with family, friends, colleagues and neighbours will enrich your life and bring you support.

Be active
Sports, hobbies such as gardening or dancing, or just a daily stroll will make you feel good and maintain mobility and fitness.

Be curious
Noting the beauty of everyday moments, as well as the unusual, and reflecting on them helps you to appreciate what matters to you.

Learn
Fixing a bike, learning an instrument, cooking – the challenge and satisfaction brings fun and confidence.

Give
Helping friends and strangers link your happiness to a wider community and is very rewarding.

This 'Five a day' campaign provides major opportunities for local government to make a contribution, from improving the aesthetic aspects of parks and green and open spaces, to enhancing sports facilities and creating new opportunities for residents to engage actively with their environments and their communities.

Work, worklessness and the local economy

At any one time around three per cent of the working-age population is off work due to illness or incapacity, costing the economy over £100bn per year (Black 2008). Almost four out of 10 adults with mental health conditions are unemployed, which represents a loss to the economy of £9.4bn. This is considerably higher than the £6.5bn spent by the NHS on mental health services in 2008. There is overwhelming evidence that being in work is a key component of mental and physical well-being.

Some 2.64 million people currently claim incapacity benefit and many of these would like to work. But if health inequalities are to be addressed it means helping all those unemployed into a job that takes them out of poverty so they are not trapped in unemployment or poverty wages which will affect their future health. There are a range of measures that local authorities can take to support people in and into work, and to support those who are unable to work or to find work. These include:

- Their environmental health and safety work to reduce deaths. Around 200 people are killed through work-related incidents every year and 5,000 to 6,000 people die as a result of exposure to materials at work.
- Acting as a role model of a 'healthy employer' and supporting other employers to tackle health inequalities by taking action to develop a healthy workforce.
- Helping people into work by:
  - putting employment advisors in GP clinics
  - encouraging employers to offer work placements and to reduce prejudice about employing people with health problems
  - specialist support and mentoring for people with health problems in work
  - intermediate labour market schemes and schemes under the Future Jobs Fund
  - providing opportunities through the council's own role as an employer
  - skills training so that people don't get trapped in low pay/no pay cycles.

Local authorities' work to support and boost their local economies is one of their less well known activities among the general public. However, for a considerable time now, they have been playing an active part in regenerating communities, promoting their areas to attract inward investment, developing training opportunities to help people improve their

employment opportunities and supporting those who are out of work, for example with welfare benefits advice.

Aawaz: Hyndburn Borough Council

Aawaz was established in 1999 to support, encourage and motivate British Asian women to engage with and access health, education and employment services. Most participants are of Pakistani or Kashmiri origin. Hyndburn Borough Council runs the project in partnership with the local PCT and GPs.

On offer are language and lifestyle sessions, normally attended by 15 to 20 women. These give women with very little understanding of English the chance to practise speaking the language.

The sessions also give advice about the culture of the Lancashire borough, including tips on how to talk in shops, interact with neighbours, book GP appointments and deal with schools.

Women have access to mental health sessions to help them cope with feelings of depression and isolation. Information is also given on keep-fit classes, guided walks and pregnancy support schemes. The project's medical adviser is on hand to deal with any health issues. Women who are pregnant and struggling with the language can be accompanied by an outreach worker to antenatal hospital appointments if they wish.

In the current economic climate, many local authorities have redoubled their efforts in this area, working with local partners to try to enhance their communities' abilities to withstand the recession, and developing programmes under the general heading of 'resilience'.

Some of the actions local authorities have been taking include:

- Supporting people in housing difficulty, including supporting new forms of intermediate housing tenure (part owned, part rented), flexibility in pursuing rent arrears, encouraging housing benefit take-up
- Promoting access to finance through debt counselling services and credit unions
- Tackling unemployment and developing skills, including short intensive adult education courses to assist in re-skilling, council apprenticeship schemes, priority to unemployed people when recruiting
- Supporting communities by maintaining flexibility and transfer between budgets and funding streams to help those most in need and allocating resources to areas of increase in service need, for example benefits and housing advice, money advice surgeries; supporting Citizens Advice Bureaux and the voluntary sector
- Supporting small businesses by encouraging rate relief take-up, developing financial packages with regional development agencies to help those in short-term financial difficulties, paying bills on time, using their purchasing power to support local small businesses
- Investing in regenerating areas with high unemployment so that more jobs are created.

Local authorities who wish to tackle health inequalities by getting those with physical or mental health problems into work need to ensure that they are facilitating and empowering their citizens by the kind of action listed above, rather than creating further stress and widening inequalities through their actions. This means helping those without a job into work that takes them out of poverty, so they are not trapped in unemployment or earning poverty wages which will affect their future health.

Better health and work

Sheffield Health and Work Strategy Group is made up of representatives from the voluntary sector, NHS, council and service users who collaborate to improve health and well-being. They develop local networks, using a holistic approach to service delivery, to help people who are in work and at risk of losing their job; those off sick; and people who are out of work and have aspirations to get back into work.

Healthy Workplaces MK, a free service from the Health and Safety Executive (HSE) and Milton Keynes Council, gives confidential, practical advice to small businesses. It provides basic advice and guidance on workplace health and safety, managing sickness absence, and return to work issues.

Leeds Mental Health Employment Consortium is a city-wide, multi-agency group, which is co-ordinated by MIND. It works to address the barriers to work faced by those with mental health problems. It has developed a vocational action plan that has been delivered over the last three years.

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The Sustainable Development Commission's Healthy Futures work programme examines the links between health and sustainable development

The Environment Agency provides resources on the links between the environment and health.

The National Institute for Clinical Excellence and Health (NICE) has published guidelines on physical activity and the environment, which examines how to improve the physical environment in order to encourage physical activity.

Building Health: What needs to be done? is a collection of papers by leading experts and campaigners which examine how the design of towns, cities and buildings might encourage physical activity.

Sustaining a Healthy Future: taking action on climate change sets out how the public health community, the NHS, local authorities, the voluntary sector and others can take action to create a healthy, sustainable and low-carbon future.

Culture and sport

Shaping places through sport www.sportengland.org/support__advice/local_government/shaping_places.aspx

Foresight Report: 'Mental Capital and Well-being' www.foresight.gov.uk/index.asp

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IDeA collection of case studies on the ways that local authorities across the country are responding to the economic downturn: www.idea.gov.uk/idk/core/page.do?pageId=9487775

Section 3 – Tools for healthy communities

Introduction

This section looks at some of the tools and ways of working that local authorities can use to enhance their health impact. Some of these, such as the local government enforcement role, have been in place for decades. Others, such as social marketing, the overview and scrutiny role and health impact assessment, are fairly recent vehicles. In other areas, such as community development, local authorities, with their NHS and other partners, are beginning to think anew about their approach and what it is designed to achieve. It should be emphasised that the tools and ways of working discussed below do not constitute a comprehensive list. They simply give an indication of some of the approaches available to local government and the ways in which local authorities across the country have used them. It could be said that the most important tools that local authorities have to improve the health of their citizens and reduce inequalities in health are the services themselves. We could, therefore, think about the approaches discussed below as methods of service delivery.

The approaches discussed here are not necessarily in competition with each other. Each of their advocates would stress that, depending on the objectives, sometimes one 'tool' is more appropriate than another, while sometimes they can be used together to reinforce their impact. Perhaps also 'tool' is not always the right way to think of these approaches. For example, as Clive Blair Stevens stresses, there is a strategic as well as an operational aspect to social marketing. And the particular approach to community development described by John Ashton requires a wholesale cultural shift in perspective.

No-one can hope to take a strategic, locality-based approach to the social determinants of health without an understanding of how those determinants play out in the local area. The first tool discussed below, local public health intelligence, is therefore a necessary basis for developing strategies. Good, detailed, properly analysed and disaggregated information about the local population, their levels of wealth and deprivation, their education and employment, their lifestyles and their life chances, as well as their state of health, should be the starting point and underpin any of the other approaches discussed.

In his section on asset-based community development (ABCD), Dr Ashton explores an approach to community engagement and health that is based on 'salutogenic' (health-engendering) principles. This is an approach that focuses on the health enhancing factors in a community, such as social capital, resilience, community development, and assets such as knowledge, skills and resources. This approach is a challenge to traditional models of community engagement, which are described by advocates of ABCD as 'deficit led'. That is, they tend to focus on the deficiencies of knowledge and attitudes through the mediation of professional services.

Social marketing tools, discussed by Clive Blair-Stevens aim to influence knowledge, perceptions and behaviours in order to improve 'lifestyles' as they relate to diet, exercise and other issues such as the use of health services, including early diagnosis and also how people care for their own health. But the evidence suggests that knowledge alone is not enough to change behaviour. Blair-Stevens is careful to make only modest claims for social marketing and to suggest that it is a way of developing systematic strategic approaches to health inequalities, based on 'a strong citizen and insight-driven approach' which suggests that it might be compatible with ABCD. Social marketing would need to move a long way from its origins in consumer research to satisfy the community-driven model developed by advocates of ABCD. Nonetheless, the emphasis of social marketers on really understanding the perspective of the communities we in the public sector serve does seem to provide a common factor with ABCD.

The enforcement role of local authorities is a very different kind of tool in the health improvement armoury and the struggle against health inequalities. As Charles Loft points out, the enforcement functions extend well beyond the more obviously relevant work of environmental health officers. One of the advantages that enforcement staff, such as trading standards officers and licensing teams, have is the access their work gives them to places where people go about their daily business and where they gather for pleasure – shops, markets, pubs, clubs and restaurants. Taking advantage of this access, enforcement officers are developing imaginative partnerships with health colleagues, such as those described by Charles Loft in his chapter. Only

a few years ago, it would have seemed very unlikely that licensing officers would get together with their local PCT to facilitate a Chlamydia testing service for young women in clubs in the small hours of the morning. Yet this is happening in Luton and other local authority areas. The emphasis on going to people where they are, rather than expecting them to come to special health locations to receive services is one of the recurring themes in this section.

Health impact assessment (HIA) is another tool that is increasingly being used by local authorities, both in the planning stages of their work and retrospectively to evaluate its impact. As Adrian Davis notes, there is considerable variation in the extent of community involvement in HIA exercises. Nonetheless, involving the people on whom the impact of a policy or programme is likely to fall is now considered good practice. It also makes good sense, both when looking forward to the implementation of an intervention and when looking back to consider its effectiveness, to include those who will be or have been effected in asking the right questions. The development methodologies and techniques of HIA should increasingly assist in the more rigorous approach to evaluation of intended health interventions argued for by Mike Kelly and Tessa Moore in their article in chapter three.

Also relatively new to local government is the health scrutiny role, described and discussed by Su Turner. In common with the other 'tools' described in this section, local authority health Overview and Scrutiny Committees are using this function to engage directly with their communities, often deciding their work programmes on the basis of health issues raised by community members. They are also finding new ways of running their reviews, in many cases moving away from the traditional committee-style meeting associated with local government, and finding new forms of engagement with people. Some of the work is done in formal hearings in public where members of the community have an opportunity to raise their concerns and hear them discussed in some detail. But elected members are also becoming bolder and more confident in being involved in less formal forums such as focus groups, community visits and visits to settings in which services are provided. The health scrutiny function is also providing an opportunity for members to develop an understanding of the wider determinants of health and the underlying causes of health inequalities. There is still a focus among health scrutiny committees on NHS care, which is perhaps not surprising, given the emphasis on acute care issues in news items. But it is to be hoped that the Marmot review of health inequalities will provide an additional impetus for health scrutiny committees to focus their intention on 'upstream' issues, including some of the issues discussed here.

Local authorities' role as an employer is important, and not only because local authorities as community leaders should provide a model of a 'healthy employer' for their area. In many areas, the NHS, local government and other public authorities are the largest employer, sometimes the only large employers. We should also remember that councils' workforces offer an opportunity to engage directly with the communities they represent, since the majority of council employees also live in the local authority's area. So improving the health of employees (and, indirectly, their families) can actually have a direct impact on health inequalities in an area.

9 Local public health intelligence

Fiona Campbell
Consultant on public sector policy and governance
Associate, Local Government Centre, University of Warwick

To plan and intervene effectively in ways which will improve health and reduce inequalities, it is literally vital for public sector and other local organisations to have a comprehensive understanding of the populations they serve and the factors that influence their health and well-being. To undertake strategic planning, they need an overview of their populations as a whole, but also a detailed understanding of the profile of different groups, including the groups who are most vulnerable and disadvantaged. There are many sources of information designed to help local areas understand and analyse their health needs and assist in planning to meet them. Directors of Public Health are required to produce an annual report which will give an overview of the health of the local population. Local authorities themselves produce a considerable amount of information for many purposes, much of which relates to the social determinants of health. Much of this is disaggregated by wards or even smaller geographical areas (such as Lower Super Output Areas which nest within ward boundaries) and is also used to produce socio-economic profiles of different groups, such as older people, young people, disabled people and people from different ethnic groups. Some sources of intelligence about local populations relate specifically to health and social care. None of these provides all the health intelligence that strategic planning requires, but together they provide a very extensive set of complementary information. The main sources of information are outlined and briefly discussed below.

Joint Strategic Needs Assessments

All areas (ie those covered by social services authorities and their relevant PCT) have a Joint Strategic Needs Assessment (JSNA) for the area. The JSNA is an increasingly important tool for planning and commissioning health and social care. Starting with what is known about the area's population and about current service provision, "it seeks to identify gaps in health outcomes with particular attention to the needs of less well served segments of the population" (Hughes, 2009).The Department of Health believes that the intelligence and data in JSNAs "ought to provide a robust local test of whether a fair and equitable approach is being taken to meet the health and well being needs of local people" (IDeA Healthy Communities website, 2010). As JSNAs are relatively new (in their third year of preparation at the time of writing) they may not yet be in a position to provide such a test. However, they should already be an important source of evidence to inform planning for health, including planning for early intervention and prevention.

At this early stage, most JSNAs concentrate on information that supports planning specifically for health and social care services, as distinct from services that relate to the wider determinants of health. Nonetheless, the intention has always been that JSNAs should include general demographic, social and environmental information, as well as health profiles; that they should be used to underpin and inform planning that is designed to tackle health inequalities and their broad determinants (DH 2007, Annex A); and that they should reach "outside the health and social care community to engage wider partners" (IDeA Healthy Communities website, 2010).

Using the JSNA to look at the wider determinants of health

The 2009 JSNA for Cumbria has a chapter on "Living conditions and health inequalities". This chapter uses maps and statistics to give an overview of relative deprivation and wealth across the county, showing where the most deprived populations are concentrated, but also notes that the majority of people in relative poverty (56 per cent) live outside these deprived areas. The JSNA also shows the correlation between deprivation, poor health outcomes and life expectancy. The strategy considers what is being done locally to impact on four major areas that affect people's health:

- services to support mothers and children
- the education system
- creating the conditions for decent employment opportunities
- access to quality housing.

Embedding this information in the JSNA enables health and social care specialists to make the links with policy and service areas well beyond their own specialisms. It also enables those working in areas outside health and social care to understand better the impact of their own work on health, and thereby fosters an integrated and

coherent approach to tackling the social determinants of health.

Cumbria JSNA, 2009: http://www.cumbria.nhs.uk/YourHealth/PublicHealthInformation/Cumbria%20JSNA%202009.pdf

The Health Inequalities Intervention Tool

To support PCT's and local authorities, the London Health Observatory has produced a Health Inequalities Intervention Tool (HIIT). The tool allows users to look at the gap in life expectancy between the most deprived quintile (MDQ) in the local authority selected and a range of comparators. It also allows them to model the impact of four interventions on life expectancy in the local authority and the most deprived quintile of the local authority selected. The interventions considered are smoking cessation, measures to reduce infant mortality, high blood pressure and the use of statins to reduce cholesterol which causes heart disease.

To some extent the interventions currently covered by the HIIT are oriented to NHS activity and to intervening once a health condition is established, rather than to tackling the "upstream" causes or wider determinants of ill health. However, many local authorities are involved in smoking cessation programmes with their PCT and in interventions to try to reduce teenage pregnancy which can result in low birth weight and poor life and health chances for the children of teenage parents. Any local authority striving to achieve its Local Area Agreement targets will be focusing on these issues. This tool can help local authorities understand the potential impact of their activities in these areas and, as such, assist in developing strategies with a maximum impact on health and health inequalities.

The Health Poverty Index

The Health Poverty Index (HPI: www.hpi.org.uk) is a web-based tool covering all local authority districts in England. It allows geographical areas and different ethnic groups to be compared in terms of their 'health poverty'. It provides a single, high level, visual summary of an area's status in terms of health poverty, drawing on over 60 indicators of health and its wider determinants.

The HPI was developed to underpin work on reducing inequalities by informing policy development, service planning and resource allocation. Rather than being a tool for monitoring inequalities and evaluating the effectiveness of interventions, the HPI has been developed as an essential summary at the start of the decision-making process as part of assessing needs and facilitating discussing within local partnerships on local priorities.

Currently, users are able to select and compare an area against England as a whole, similar areas in terms of ONS family classification, or another local authority. It is also possible for HPI users to compare areas against the Spearhead Group of local authority areas. A Health Poverty Index workbook has also been developed which guides the user through some of the features of the tool and demonstrates how the tool can be used.

Local Health Profiles

In June 2006 a set of community health profiles for England were first published. Local authority health profiles are designed to show the health of people in local authorities across England. They cover all but two of the 388 local authorities, including county councils, district councils, unitary councils and London boroughs. (City of London and Isles of Scilly are not covered due to data limitations.) The profiles have been produced by public health observatories and have been updated every year. This means that they can now be used by local authorities for historical comparisons and to evaluate progress. They cover a very wide range of indicators, including deprivation indicators and those covering many of the wider determinants of health, as well as "lifestyle" indicators like local rates of obesity, physical activity, smoking in pregnancy and breastfeeding and long- and short-term medical conditions like diabetes and hip fractures. Regional profiles were also created for the first time in 2008 to provide a ranked comparison of local authorities and counties within each region.

These health profiles can be used by local authorities and the health service to highlight the health issues for their local authority area and to compare them with other areas. The profiles are designed to show where there are important problems with health or health inequalities. The profiles can be used with other local information, such as the Audit Commission's Area Profiles, to target action to improve the health of local people. The Profiles can be found at: www.apho.org.uk/resource/view.aspx?RID=50202

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10 Inequalities, assets and local government – opportunities for democratic renewal posed by the global economic crisis

John R Ashton CBE
Director of Public Health and County Medical Officer Cumbria
Chair UK Public Health Association

According to John McKnight speaking in lectures and workshops across the north-west last year, 'you don't know what you need from the store until you've looked in your own backyard first'. This metaphor, which contrasts a consumerist approach to public sector services with one based on collective self determination and asset husbandry, is at the heart of McKnight's work at Northwestern University in Chicago over the past 35 years (Kretzmann and McKnight 1993).

McNight was a close friend of the late Ivan Illich, whose critiques of the disempowering effect of conventional medical and educational practice in the 1960s was part of the intellectual cocktail of stimulants at that time (Illich 1975). McKnight and his group have been acknowledged by US President Barack Obama as having taught him more in the three years it took to become a community organiser in downtown Chicago than in his years of study at Harvard Law School. The language in Obama's speeches gives more than a clue, with its constant emphasis on 'we' rather than the usual politician's 'I' and the recurrent sense of bringing people together to solve problems collectively, rather than seeking nostrums from outside.

So what is Asset Based Community Development (ABCD), as expounded by the Chicago School, and why could it be central to re-energising democracy and public services after this year's general election, and at the same time creating a real opportunity of doing something about social and health inequalities?

We know from our own experience in this country that inequalities are entrenched and, if anything, are growing. We also know that despite a massive emphasis on public service solutions, there is a general disillusionment with local and national government and an alienation from our political representatives (Ashton 2000). There is a feeling that our institutions of government don't work and that the services they provide are nannying, paternalistic and unresponsive. On the other hand there is a sense that the public has unrealistic expectations of services which they are not prepared to pay for. McKnight's analysis points to the vicious conundrum which has been collusively created by treating the public as consumers, and politicians as infallible parents who have all the answers. Child-like dependency and adolescent heckling are the inevitable outcome of such an unbalanced approach to resource allocation and the realisation of millions of individual and family aspirations.

'Red Tory' philosopher Philip Blond is receiving increasing attention for his views on the Welfare State. His argument, that it has disempowered working class people by taking away their ability to self-organise, strikes a chord with those familiar with the rich range of community assets such as the cooperatives, friendly societies, working men's clubs and the trades unions themselves which were part of the original infrastructure that created the Labour Party. By implication, the main beneficiaries of the white collar public sector have been the new middle class, who have left the remains of the industrial working class behind.

For McKnight, whose work has until now been little known on this side of the Atlantic, individuals and communities are always half full, not half empty. Everybody has gifts and talents, and in emasculating citizens from participation we not only score an own goal, but we squander massive amounts of energy and resource and fail to use public assets to the full.

McKnight's work sits alongside that of Robert Putman, whose book Bowling Alone is a bible for understanding social capital and which has itself been very influential in recent years, especially in North America (Putnam 2001).

A disciple of Saul Alinsky, the North American father of community development, McKnight's academic work began with the establishment of the ABCD Institute in the 1970s. The programme of teaching and the training of community organisers was based on 3,000 stories captured from household and neighbourhood interviews. These stories were derived from the answers to a single question: "Can you tell me what people who live in this neighbourhood have done together to make things better?" The result was a framework for mapping the assets of communities where change was possible, and a set of tools described in the best selling Community Development manual, *Building Communities from the Inside Out* (Kretzmann and McKnight 1993).

All stories had five components:

- individual local residents with skills, abilities and assets (gifts) who believed that they could make a difference with regard to a particular issue
- small groups of individuals (active citizens) getting together (associations) to pool their gifts for the common cause (unpaid)
- groups of local people getting together to do something, but who are paid to do it (organisations, businesses, NGOs)
- physical assets and resources such as buildings, land and transport
- a process of exchange and facilitation linking the first 4 (connectors).

All the stories were about unconnected assets becoming connected.

From an Asset ABCD perspective, the critical community-building issue is how local residents and their associates produce a result – from consumer to producer. In the United States context, as well as in the UK, 'participation' or 'collaboration' usually means that the real producer is an agency or government. In ABCD, the agency or government has a supportive role.

On the recent visit to the north-west, McKnight illustrated the work of Asset Based Community Development with many stories, but the following were typical:

In answer to the question about what had happened recently to make a difference, a single mother of a teenage girl said that during one school holiday, and a couple of years before she had reached puberty, her daughter had begun going around with another girl. By the end of the holiday, both girls' mothers were worried that their daughters were going off the rails. They decided to do something about it, and came up with a list of activities that they might pursue with their daughters in the next school holiday. Realising that, as working single mothers, it would be impracticable to pursue the list, they found several more mothers with the same predicament, and together came up with a solution whereby they could take it in turns to have the group of girls for a day. The outcome was a programme for the school holidays with several strands to it.

- A visit to an insurance office where the firm willingly put on talks about insurance, the business and the job opportunities. An interesting day's outing, as a group had the bonus of prompting the girls to broaden their thoughts on their futures in the world of work beyond becoming pop singers.
- Contact was made with the local park keeper, who agreed to the use of a room in the park office for group sessions. These sessions brought in members of the local community with arts, crafts and music skills as volunteers to run sessions with the girls.
- A weekly project of community benefit included one in which the girls designed coats of arms for each household in the neighbourhood illustrating the families' backgrounds and histories. These were then translated into flags which were hung on each house.

According to the witness, "by the end of the school holiday we had become a real community; the mothers had got to know each other; the girls had got to know each other and the mothers had got to know their daughters." (and barely a professional in sight).

In another story (soon to be familiar?), the state schools were required to make 10 per cent budget cuts. One local school responded in the usual 'soft touch' manner by doing away with the music and arts teachers. The community responded by mapping the local assets and finding over a hundred volunteers with arts and music skills willing to become involved with the school. So successful was this initiative that the school has since become an acknowledged Centre of Excellence in these areas.

In this country, community development has had a chequered history, with an organisational and professional ownership that has moved around between adult education, housing, local government and regeneration. Most recently there has been interest from health. At a conference held in Salford in 2000, the focus was on answering the question, "What would it mean for the public sector to function in a community development style?" (Gowan 1999 and Ashton and Hobbs 2000) The public sector seems to have always found this difficult because of a deeply entrenched, paternalistic approach to delivery.

Politicians in particular can seem threatened by active citizens providing leadership in their own communities, either alone or in association. What McKnight's work teaches us is that Community **organisation** in contrast with **development** can celebrate active citizenship and collaborative problem-solving to everybody's benefit. The challenge is to place this approach at the heart of policy.

One of the constant challenges for ABCD is continually to build and rebuild the relationships between and among local residents, local associations and local government and public sector organisations. Relationships are very important in ABCD for every person and group in the community.

Those relationships will always be based upon the strengths and capacities of the parties involved, never on the weaknesses and needs.

To support this approach, it is essential to have robust evaluations of projects and programmes. Public sector partners have a vital role to play in supporting and leading this evaluation. The outcomes have to meet the outputs and targets by which all organisations are measured. However, they must also meet the requirements of the community. ABCD gives an opportunity for local public sector partners to develop strong links with local universities to support ABCD, both in terms of research and of evaluation, alongside training and support for public sector organisations and community leaders.

For McKnight the starting point is a change of language.

From	deficits	To	assets
From	problems	To	opportunities
From	charity	To	investing in assets orientation
From	grants to agencies	To	investment and leverage
From	the good society = more services	To	the good society = less services
From	emphasis on agencies	To	emphasis on associations
From	a focus on individuals	To	unit of analysis of neighbourhood
From	maintaining clients (client = Greek for 'on your back')	To	development of citizens
From	fixing people	To	developing potential
From	programmes are the answer	To	citizens are the answer

A sense of déjà vu pervades us. In the lead up to the 1979 General Election, the Black Report on Inequalities in Health was published (Townsend and Davidson 1980). Thirty years later as Michael Marmot's report on inequalities is received, we look towards a general election in 2010 in which the old solutions will not be an option, whoever is in the driving seat. Thirty years of initiatives from both major parties of government have largely failed.

The tantalising vision and prospect is of a new settlement between individuals, communities and the public sector where co-production is a real possibility. The very fact of having well-developed public service systems in the UK, compared with the USA with its traditional suspicion of government, means that we are well-placed to deliver a different type of public service if it can be re-orientated to be enabler, connector and resource investigator.

Now is the time to honour the work of John McKnight and to give life to an idea whose time has come.

NOTE:
I wish to acknowledge the contribution of Professor John McKnight to my thinking about public health and public services and Professor McKnight's comments on the draft of this article.

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11 Integrating social marketing into what we do

Clive Blair-Stevens
Director of Strategy and co-founder National Social Marketing Centre

Over the last decade there has been a growing appreciation at local, national and international levels, that social marketing approaches (where they are properly carried out) have real potential to strengthen the impact and effectiveness of local and national programmes.

In the UK the Government in 2004 agreed to commission a two year independent review to specifically assess its potential, and, with Professor Jeff French, myself and a small team produced the 'It's our heath!' independent review report in June 2006.

At its core it concluded:

"Where social marketing was properly integrated alongside existing approaches it has great potential to not only enhance efforts to improve health and well-being, but also to better tackle often entrenched health inequalities. It can do this by providing a strong citizen- and insight-driven approach, while at the same time helping assess the wider social and societal context that impacts on peoples lives, and help in the more systematically assessment of key 'upstream' social determinants issues."

(Clive Blair-Stevens 2009)

While in the UK social marketing may for some still be relatively new, it has been around for many years, coming out of debates in the 1950s and first being coined as a term by Philip Kotler in 1971. Originally it arose because some marketers back then began to question whether instead of just being able to sell more baked beans or Ford cars, they might actually be able to use their skills for more socially beneficial causes. However, like all good disciplines, social marketing has developed and matured.

While originally often simply presented as being about harnessing commercial marketing methods, in the last decade or so, social marketing has developed by integrating learning from many areas, such as the wealth of learning from social behavioural sciences, from health promotion, public health, community development and environmental approaches. There is now a wider appreciation that effective social marketing is much more than just a limited 'marketing' set of approaches and it is now being seen as a much more 'mature and integrative discipline or approach'. Hence, in box 1 above, note the inclusion of the word 'alongside' to emphasise this integrative aspect to good social marketing practice.

Distinguishing strategic and operational social marketing

It is important to recognise that social marketing can be approached in quite different ways. It is common for people to simply see it as a programme or campaign, 'tool' or 'method' – or what can be described as 'operational social marketing'. This is important and certainly the methods and tools within social marketing can significantly assist effective programme or project development.

However, importantly, social marketing can also be approached at a strategic level. This is where social marketing's focus on gaining a deeper contextual understanding and insights into people's lives can be used to directly inform policy and subsequent strategy development, long before any particular programme or campaign is decided upon.

The UK has increasingly been recognised as taking an international lead in this area; and work to connect social marketing with social determinants is part of this. The Department of Health, in particular in its 'Ambitions for Health' strategy, is working to integrate social marketing strategically across its policy and programmes.

It is helpful therefore to think of social marketing more broadly as a citizen- or customer-focused 'mind-set' that can inform policy and strategy discussions rather than just being seen as a particular tool to help do better campaigns. This is particularly important when it comes to addressing inequalities, since by adopting a more 'strategic social marketing' approach, the wider social determinant issues can really be assessed and then addressed.

In a nutshell… understanding, insights and behaviour

At its heart, it's all about developing a deeper contextual understanding and insight into people's lives, and then using this to craft interventions and approaches that are valued by those being addressed, which can achieve measurable impacts in what people actually do – their behaviour. The key words to take away here are therefore 'understanding', 'insights' and 'behaviour'.

This means effective social marketing goes way beyond trying to communicate information, build awareness or even influence attitudes. Social marketing should never be confused or conflated with 'social advertising'. While such information and message-based approaches can be valuable in specific contexts, effective social marketing goes beyond this to focus on how to achieve and sustain behaviour, rather than just communicating a message.

The key features of social marketing have been summarised in the 8 point national benchmark criteria sheet [Box 2]. These were developed to help people assess whether work being described was consistent with its key principles and approaches.

With the rise of social marketing and growing interest of those commissioning work at local or national levels, increasingly people have started to describe what they do as 'social marketing'. This is understandable but simply calling something social marketing doesn't make it good (or bad); what matters is that the work described is consistent with key features and criteria.

Integrating social marketing doesn't mean you have to become an expert over-night. The National Benchmark Criteria sheet therefore is a very simple and practical tool to assess whether what is being described as social marketing is really consistent with its key features. For example: commissioners of services (who do not need to be expert social marketers) are increasingly adding the sheet to their tender briefs, and asking those putting in proposals to indicate how they will ensure these will be incorporated into the work proposed. This is a simple, low cost way to begin to ensure the criteria are increasingly informing programme or intervention development. Similarly evaluators can also use the sheet to guide review of work and retrospective assessment of the extent to which work has integrated key social marketing criteria.

Finally it is important to recognise that there is a great deal of excellent work going on within local communities already. This may not be formally described as social marketing, but quite often it is consistent with key social marketing principles or criteria. Building on these as important assets within communities is key. The more we can find practical ways to integrated social marketing approaches into existing programmes (whether they choose to describe themselves as social marketing or not), the greater the chance that our collective efforts to address the key social determinants will begin to show a real impact on the entrenched inequalities that exist.

References and further reading

Further information is available via the National Social Marketing Centre website www.nsmcentre.org.uk

It's our health! – independent review of health-related campaigns and social marketing in England: www.nsmcentre.org.uk/what-is-social-marketing/independent-review-its-our-health.html

12 The enforcement role of local government as a tool for health

Charles Loft
Policy Officer,
Local Authorities Co-ordinators of Regulatory Services (LACORS)

Public health is at the heart of local authorities' role in enforcing environmental health, and trading standards regulations and the origins of the environmental health profession lie in the public health crises of the nineteenth century. Today these regulatory services have a significant role to play in ensuring that the environment in which we live, work, and play enhances our health, creating healthy workplaces, reducing alcohol and tobacco related harm, maintaining acceptable standards of private rented housing, improving air quality, food standards and safety, and ensuring consumers are sold safe, properly functioning products.

Local authorities' enforcement responsibilities are often utilised in conjunction with national regulators such as the Health and Safety Executive (HSE), the Food Standards Authority (FSA) and the Environment Agency, although the nature of the relationship varies depending on the regulatory area.

Enforcement powers in these areas provide authorities with the ability to prohibit practices, products or equipment on an emergency basis where there is an immediate risk; to require improvements or changes to be made where appropriate; or to prosecute. Where activities are licensed, enforcement may take the form of removing or attaching conditions to the licence. None of these powers is used lightly. Most businesses want to comply with the law and local authority inspectors are encouraged to take an educational approach, only taking enforcement action where there is an immediate threat to address, or where a business simply refuses to comply in relation to a significant issue. Recent research has shown that businesses (especially small and medium sized enterprises) tend to value local authority inspections as a source of free advice and assistance. Nevertheless, enforcement powers are an essential backstop ensuring the majority of compliant businesses are not disadvantaged by unqualified or unscrupulous trades' people, and the advice tends to be acted upon.

The powers of inspection which local authority regulators have – and their knowledge of local businesses – combine with enforcement powers to put them in a key position in partnerships delivering public health. Striking a balance between education and enforcement is a job for individual authorities, but an approach based on 'education first', with subsequent enforcement to deal with those businesses that continue to commit significant breaches, is not unusual.

What does this mean in terms of practical policies that impact upon the social determinants of health? In 2008, Liverpool PCT commissioned the city council's private housing team to undertake additional enforcement and inspection activity, combined with referrals to GPs and community health teams where appropriate. This programme recognised not only the impact of poor housing on life expectancy (a ten-year difference between the city's richest and poorest wards) but also that council inspectors were ideally placed to reach members of the community who might otherwise not be seen by GPs. While the council sought to work with businesses, it was made clear that enforcement had a role to play where landlords showed a disregard for their tenants' health. Prosecution in these sorts of cases also allows the majority of businesses to feel secure that they are not being undercut by rogue operators.

Health and safety is often seen as being simply about preventing accidents in the workplace, but health promotion is increasingly part of regulators' work. The Local Authorities Coordinators of Regulatory Services (LACORS) has worked with HSE to deliver a number of health campaigns, for example on dermatitis, stress and work-related violence, as well as ongoing local authority work on asbestos. Again these are typified by an educate-first approach where enforcement is a last resort and - arguably – an incentive to get educated.

Sometimes however it is appropriate to take immediate legal action, for example when food outlets are found to be posing a serious health risk.

The successful Smokefree England campaign provided an ideal example of how local authority regulators can deliver public health outcomes, and of the role of enforcement in that process. Enforcement action by local authorities has been minimal because widespread educational work by local authority inspectors in the lead-up to implementation of the smoking ban succeeded in achieving overwhelming levels of compliance. The professionalism of council environmental health officers and their existing links to local

business were vital in this process. But where the law has been blatantly flouted – and where duty holders have faced intimidation when attempting to enforce it - enforcement has proved effective in preventing disregard for the law spreading. As tobacco policies move forward from Smokefree implementation, trading standards officers and environmental health officers will be using enforcement to tackle the residual problems in tobacco control – underage sales and illicit tobacco.

Further information on the contribution of regulatory services to public health can be found in the pamphlet, *Taking forward the health role of council regulators* (IDeA and LACORS 2009).

References and further reading

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Local Authorities Co-ordinators of Regulatory Services: www.lacors.gov.uk

13 Health impact assessment

Adrian Davis
Public health and transport consultant,
NHS Bristol

Health impact assessment (HIA) is increasingly seen as a useful tool with which health impacts of policies, programmes and interventions, and their distribution across the population can be assessed in order to enhance the positive and reduce negative health impacts identified.

HIA is the term given to the process by which the health impacts of certain plans, policies or actions are judged. The World Health Organisation has succinctly defined an HIA as "a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population". In HIA a social model of health is applied which acknowledges the influence of economic, political, social and environmental factors on population health. HIA considers the health impacts of a specific proposal on a defined population, usually over a specified time interval. There is an explicit focus on health inequalities by giving specific consideration to whether impacts of a proposal fall disproportionately on vulnerable or minority groups. For example, there are now a considerable number of HIAs of road transport policies and interventions (APHO 2009).

HIA methodologies vary, with some utilising similar approaches to that of Environmental Impact Assessment (EIA) and Strategic Environmental Assessment (SEA) (Mindell 2003a and 2003b). Integrating HIA with such assessments can lead to more informed and rounded assessments.

Importantly, recent Local Transport Plan 3 (LTP3) guidance states that consideration of human health is a legal requirement in SEA and HIA is an integral part of SEA to identify and inform health issues in plans (Department of Transport 2009). Consequently, all highway authorities in England now have to undertake HIAs of their LTP3s as these are developed and then replace LTP2s from April 2011.

The HIA process involves collecting a wide range of evidence in order to interpret health risks and potential health gains. It presents this information, along with recommendations, to decision makers. It has been noted that HIA is a process that:

- considers the scientific evidence about the relationships between a proposed policy, programme or project and the health of a population
- takes account of the opinions, experience and expectations of those who may be affected by a proposed decision
- highlights and analyses the potential health impacts of proposals
- enables decision makers to make more informed decisions and to maximise positive and minimise negative health impacts
- enables consideration of effects on health inequalities.

Prospective HIAs undertaken alongside policy development afford the greatest opportunity to influence and to change draft policies, so that any potential negative health impacts can be avoided or reduced, and any positive impacts enhanced. There will, however, be issues about which there is little or no evidence and it will be important to acknowledge these, as well as the uncertainties and assumptions that need to be acknowledged. Some required evidence may not exist, such as the outcome of specific interventions.

HIA can be undertaken in varying levels of detail as a rapid process, intermediate, or a more in-depth full study, depending on the resources available, and it can be applied to policies, programmes or projects. HIAs usually include a number of stages of which 'screening' - whether an HIA be undertaken – has already been determined by the client.

The Scope (see below) will be determined by the parameters of an HIA approach and funds potentially available. Stages include:

- scoping – agreeing how best to undertake the HIA
- appraisal – identifying, examining, considering best available
- recommendations – formulating and prioritising.

(The latter two to be undertaken by HIA specialists)

A review of HIA frameworks has reported that approaches to HIA reflect their origins, particularly those derived from EIA. There are more similarities than differences in

approaches to HIA, with convergence over time, such as the distinction between 'narrow' and 'broad' focused HIA.

Consideration of health disparities is integral to most HIA frameworks but not universal. A few resources focus solely on inequalities. The extent of community participation advocated varies considerably. A conclusion is that it is important to select an HIA framework designed for a comparable context, level of proposal and available resources.

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14 Using scrutiny to improve health and reduce health inequalities

Su Turner
Health inequalities programme manager,
Centre for Public Scrutiny (CfPS)

The role of overview and scrutiny was introduced in local authorities by the Local Government Act 2000, to complement changes in executive arrangements. An additional role of scrutiny in relation to health was conferred on local government by the Health and Social Care Act 2001.

The scrutiny committees of local authorities undertake a public process of holding decision makers to account; both within local councils and other public services such as the health service. They also review the performance of local authorities themselves, and other public services.

Health scrutiny is seen as a lever to improve the health of local people, ensuring that their needs are considered as an integral part of the delivery and development of health services. It is increasingly mentioned by both local authorities and their NHS partners as one of the important ways that local authorities can respond to the concerns of their residents.

It is a means of enabling councillors to scrutinise how local needs are being addressed, how health services are run and how they can be improved. It also provides an opportunity for local councillors to offer practical solutions or ways forward. Health scrutiny committees are encouraged to build on the community leadership role of local government, to promote the social, environmental and economic well-being of their area.

Using scrutiny to improve health and reduce health inequalities

Scrutiny committees have the difficult task of attempting to hold to account their local NHS and the health (or sickness) services it commissions and provides, while at the same time holding to account all those local organisations, including their own council, which have an impact on the wider determinants of health.

Despite this enormous remit and despite pressures to spend much of their time reviewing acute health services, many health overview and scrutiny committees have used their powers to tackle health inequalities and to make recommendations to local and national agencies on how their work can be improved. Some examples are given below.

- Hartlepool Borough Council's health scrutiny forum looked at how the authority and partner organisations targeted those families in most need of support.
- With support from the CfPS members from Warwickshire County Council, Coventry City Council and Solihull Metropolitan Borough Council undertook a joint review looking at excess winter deaths and fuel poverty across their sub-region.
- Middlesbrough Council's social care and adult services scrutiny panel carried out an investigation to look at how the council and its partners are working to help people with disabilities into paid and meaningful employment.
- The health overview and scrutiny committee undertook an in-depth scrutiny into childhood obesity in Warwickshire. The review focused on the extent, causes and consequences of childhood obesity and what the NHS and local authorities do to meet the needs of those affected.
- The London Borough of Hackney carried out a review looking at unemployment and its impact on health. It used an innovative interview technique to understand how local services can help to prevent short-term sickness from progressing to long term sickness, and ultimately worklessness.
- Many overview and scrutiny committees have carried out investigations into obesity in their areas and made recommendations to a number of agencies inside and outside the council, both local and national.

Health overview and scrutiny committees have also raised the profile of their councils' health role and advocated for the council to tackle health inequalities through its own services. For example:

- The London Borough of Haringey held an event and produced a report which looked at key health inequalities in the area, and the wider determinants of health, and highlighted the links between all aspects of council work, not just the health care service.

Following each review, the Overview and Scrutiny Committee (OSC) summarises its conclusions and makes

recommendations addressed to whichever organisations are in a position to implement them. It is still early to assess how effective OSCs are in bringing about changes to improve health and reduce health inequalities in their areas, since the social determinants of health have long-term effects. However, there is evidence that at the very least, the agencies to whom scrutiny committees make recommendations feel obliged to show how they are addressing the issues under scrutiny. Many OSCs review the impact of their investigations after some time and are able to point to changes in services or other forms of intervention that have been made in response to their recommendations. In this way, they can give health inequalities a greater profile. By carrying out their work in public they can give a voice to those who often go unheard, and they can highlight non-acute but vital health issues which are sometimes given a low priority because of pressure from acute health services.

The CfPS recognises the potential that scrutiny has in tackling health inequalities. It is leading a programme (funded by the IDeA's Healthy Communities programme) to raise the profile of overview and scrutiny as a tool to promote community well-being and help councils to address health inequalities within their local community.

References and further reading

Further information can be obtained from the Centre for Public Scrutiny at www.cfps.org.uk. The website has a comprehensive searchable library of scrutiny reviews on which all the reviews referred to above can be found.

15 The local authority as employer

Fiona Campbell
Consultant on public sector policy and governance
Associate, Local Government Centre, University of Warwick

Local government employs over two million people and is one of the largest employers in the UK. Individual local authorities are major employers – often the second largest employer in an area after the NHS. As such they have responsibilities and opportunities to look after and improve the health of their workforce. Because they employ a huge range of staff doing many kinds of work, their role as employer could help them make real inroads into reducing health inequalities in their area.

An obvious example of where they can make a difference is in the pay structures, levels and conditions of service for their employees and pensioners since income is one of the biggest social determinants of health. Local authorities have also been pioneers in some forms of 'family-friendly' employment policies, such as flexible and term-time working. As Dorling points out in chapter two, something as simple as enabling working parents employed by the council to have time to breakfast with their children can make a difference to the children's education and, therefore, their life chances and their overall health. But there are also more specific interventions, directly targeted at the health of employees.

The Government has calculated that the public sector in England, which includes local authorities, spends £1.8 billion on food and catering services each year. It wants the sector to use this buying power to help deliver various objectives, including increasing consumption of healthy and nutritious food, and increasing the contribution of local suppliers. The Government launched its Sustainable Food Procurement Initiative and has provided guidelines to assist the public sector, including local authorities, in procurement of food using sustainable development objectives. Many local authorities provide places where staff can purchase food. which therefore offer direct opportunities to provide safe, sustainable and healthy food. All local authorities also provide food at events hosted by the authority and attended by staff and councillors. Councils are gradually beginning to realise that it is not a good idea to promote healthy eating and access to nutritious food in their communities while continuing to offer a diet of fish and chips and tired municipal sandwiches to their staff and elected members. In both provision and procurement, local authorities are increasingly considering how they have regard to emerging expert advice on healthy eating.

Many employers, including local authorities, are offering incentives and opportunities to staff to take more exercise. For example, there's really no excuse for any local authority not to join the national Cycle to Work scheme. This is a tax incentive aimed at encouraging employees to cycle, thereby both reducing air pollution and improving fitness. The scheme allows employees to benefit from a long term loan of bikes and commuting equipment such as lights, locks and panniers, completely tax free. Employers can lend bicycles to their staff as a tax-free benefit on the condition that the bicycles are mainly used to get to and from work or for work-related purposes. The employee 'buys' the bike at the end of the load period for a nominal sum.

For those who don't want to or can't cycle, councils are big enough employers to run aerobics classes, facilitate and promote regular 'health walks' at lunchtime for groups of staff, and provide pedometers and health checks.

Offering health checks to staff – such as blood pressure and cholesterol tests –with the help of the local public health directorate provides opportunities to give or direct employees to further support, such as smoking cessation services.

Perhaps some imaginative councils having watched television documentaries which showing the enormous impact singing and dancing have on people's well-being, both mental and physical, will be inspired to start choirs and dance classes for their own staff.

Barnsley MBC

Barnsley Metropolitan Borough Council participated in a workforce development pilot scheme run by the IDeA's Healthy Communities team. The pilot was to see whether health improvement interventions could be introduced to manual workforces at the same time as raising knowledge of health issues in the community.

The Smithies Depot in Barnsley is the notional base of approximately 350 staff – mostly men in manual roles. It was decided to offer comprehensive health checks for up to 150 men and women. To encourage the men to come, a healthy breakfast was provided free of charge. In addition to the food offered as incentives, 150

pedometers were given out for a pedometer challenge where the highest amount of steps won a signed Barnsley Football Club football in a display case. Once the staff were 'enticed' to the canteen area they could participate in a health check or visit one of the stalls that were present to get health advice. Stalls included information on:

- smoking cessation
- The DAAT (Drug and alcohol team)
- benefits information
- emotional well-being
- Healthy Communities Collaborative
- Barnsley Premier Leisure.

Other prizes were given out for attendance. Stalls gave out a loyalty card and each time someone visited a stall the card was stamped. Six stamps got them a raffle ticket for a signed Barnsley FC football shirt.

Demand was so high for the health checks that an additional 100 were performed.

A 'grab and go' scheme has now been introduced where a local caterer comes to the canteen every morning to sell healthy lunches for the men to take out on the road. The prices are subsidised and the initiative is a joint intervention between the PCT and the council. The council can already point to a small but significant improvement in the health of the Smithies workforce.

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IDeA
Layden House
76-86 Turnmill Street
London EC1M 5LG

telephone 020 7296 6880
facsimile 020 7296 6666
email ihelp@idea.gov.uk

www.idea.gov.uk

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