

Maintaining our momentum

Essays on four years
of public health

About this publication

Public health made the formal transfer to local government in April 2013, and in the last four years great strides have been made to tackle the wider social and economic determinants of poor health. This publication was commissioned by the Local Government Association (LGA) to capture the thoughts of those working hard to make the new system work with contributions from councillors, directors of public health, providers, commissioners, academics and other key decision makers.

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.

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The views expressed in the publication are those of the contributing authors and do not necessarily reflect the views of the LGA.

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Foreword



**Councillor
Izzie Seccombe**
Chair, LGA Community
Wellbeing Board

After four years, I hugely admire the way directors of public health (DsPH) and their teams, with the support of council leaders, cabinets and chief executives, remain full of commitment and inventiveness, despite the financial barriers they face.

Good public health, drawing imaginatively on all of local government's functions, can make a real, large-scale difference to promoting the independence of people with long-term chronic conditions, to preventing ill health and therefore to reducing pressures on the NHS, as well as to its primary goals of improving people's lives and wellbeing and reducing health inequalities.

Good practice from individual councils shows just what potential there is for public health, if properly resourced, to make inroads into improving health and wellbeing. Public health teams, working with a 'health in all policies' approach across councils, are tackling persistent problems like adult and childhood obesity, mental illness, alcohol abuse, sexually transmitted infections and the health impact of isolation and loneliness in old age, as well as addressing some of the serious health inequalities that still exist within and between communities.

Already, we see DsPH beginning to build on their understanding of the impact of most local government functions on the social determinants of health.

However, the context for all the excellent work is the relentless reduction in the resources available for public health work. Councils and their public health teams have put a brave face on the compromises they have had to make, working with the local NHS and voluntary sector, sharing public health initiatives and sometimes even public health teams across councils, reorganising in an attempt to achieve more with less.

I take my hat off to their resilience and passion but I want to reiterate my plea for properly resourced public health services across the country. The renewed public health function of local government has only just got started and it cannot continue to maximise its role at the heart of councils while continually retrenching to make budget cuts.

We must not get used to the NHS and social care being in a permanent state of crisis. Public health could help make this country one where people live healthy lives for longer with less dependence on acute health and care services and a better quality of life, while reducing the public service budget in the long term.

Responding positively to the opportunity to influence population health



Lord Andrew Lansley
Secretary of State for
Health 2010-2012

It is four years since the transfer of public health responsibilities to local government and into the more independent Public Health England (PHE). It is clear that PHE is building on the Health Protection Agency's reputation for high-quality science with a new appetite for tackling public health issues, like sugar in our diet.

The rationale for a local government lead is unchanged: that the greatest impacts on health are in the circumstances in which we live, employment, education, environment and the effects of the social gradient of health, that is, equality or the lack of it. And local government, while often limited itself in its influence, can certainly impact more on these factors than the NHS.

As always with any change, some embrace it, some resist and many wait and see. After initial reluctance, I see many in the public health professions responding positively to the opportunity to influence population health. But they, and many in local government have been frustrated.

First, by the failure of central government to live up to the promise that public health budgets would no longer be eroded by NHS pressures. My 'ring-fence' agreement on health spending included public health and health education within the ring-fence. The recent settlement raided both, to enable the increase in NHS budgets to meet the real-terms target. This undermines our long-term need to moderate health need and provide our future workforce.

Secondly, in local government, the needs of social care are pushing out the space for reform in health generally. The need to integrate health and social care is not new, nor are many of the solutions. Pooled budgets and integrated commissioning have been developed over decades. Personal budgets are an essential component to making care work seamlessly for care users and their families. But the public health community know that this is a limited solution when the drive was for local government to bring the democratic voice and preventative approaches on a population basis to health delivery; but, too often, Sustainability and Transformation Plans (STPs) are being constructed on an insular 'NHS knows best' model.

Clinical commissioning groups (CCGs) and local government, through the health and wellbeing boards (HWBs), were given by the Coalition Government the powers to create integrated health planning. It should mean joint commissioning. This should be led by the public health profession, using population health management techniques to tackle the factors driving rising demand, including risk factors like obesity, inactivity, tobacco, drugs and alcohol, but also seeking to shape the environment on issues like air quality and green space.

Population health management, as a basis for proactive joint commissioning of local health and care services, should be the means by which local government and the NHS reshape service delivery to meet growing demand; not by the NHS retreating to old-style reconfiguration or trying to manage demand by restricting supply. Local government has the legitimacy and the record of efficiency gains and commissioning experience to provide leadership in this process. The NHS must use it.

Healthcare alone cannot be responsible for the health of the people



Duncan Selbie
Chief Executive, Public Health England

The transition of public health from the NHS to local government is now complete thanks to extraordinary leadership shown by both national and local government to move beyond plans and words and realise change on the ground – public service reform in action.

The recognition that this was absolutely the right decision and that our confidence in local leaders was well placed was confirmed by the Health Select Committee in its report on the new public health system post-2013, in which local government was endorsed as the best home for the local leadership of the public's health. Now it is time to look forward.

DsPH have quickly adapted to new and wider responsibilities and the need to shape the places in which local people live within changing political contexts – an experience that most would not have encountered previously.

They have truly landed on their feet, and while there is more maturing to come in these relatively new roles, what is really exciting is the development of a new covenant between national and local government that understands what really matters to people living in places: having a decent job, a warm home, a safe community and someone to talk to.

These are also things that have a big impact on health outcomes, yet sit outside the traditional realms of healthcare. The understanding that healthcare alone cannot be responsible for the health of the people must now become the norm and infuse all of us in how we think and plan and act. Local government has led this approach for some years; it is time for the NHS and everyone else to catch up.

The real opportunity here lies in devolution, and all over the country local areas are joining together – from Greater Manchester to Cambridgeshire and Peterborough – to take back control of the services that affect their local populations in the reasonable belief that what they can provide will be better than anything organised from the centre.

More local, joined up and innovative ways of working are also inherently linked to the need for better fiscal discipline, and this is likely to continue. The way that we use our money cannot be constrained by history and what has been done before. Nor can we afford to experiment. We need to be led by experience and evidence of what works.

Public health professionals offer a unique skillset here that should be further exploited. They understand how to analyse the data and use it to help make the right decisions on how and where to invest precious resources.

Of course, there remains an important role for national policy making but this cannot be a substitute for local leadership and local responsibility for improving the health of local people. It is right that those decisions are being made where the action happens.

We need both strategists and pragmatists



**Professor
Gina Radford**
Deputy Chief Medical
Officer

As Deputy Chief Medical Officer, invariably I have a perspective that is national, although it wasn't that long ago that I was working in a local authority and later in PHE. That's one of the great things about public health – the variety of roles that public health professionals undertake.

So what do I see as the public health challenges and opportunities we face in 2017 and beyond? I think many are broadly the same as in recent past! I admit I am a glass half full person – I think public health par excellence is about looking for opportunities and seizing them – we need to be both strategists and pragmatists. Clearly new to the agenda is Brexit, with its challenges but also opportunities. An ageing population, rising levels of obesity and various long term conditions, pressures on health and social care remain with us. Global health security and the potential of a new pandemic are on the horizon. Air pollution and its consequences is rising up the agenda. We have opportunities such as the Childhood Obesity Plan, the STPs, the increased focus on work and health and economic sustainability, the interest in social justice to name a few. I'm also excited about the potential of exploiting digital solutions – though I am SO not the right generation to even begin to understand the full potential these offer! These are but a few.

I am very aware that sitting as the elephant in the room for many colleagues is of course the question of resources. Now the Government has made it clear that local authorities' future public health funding will come from retained business rate funding, that signals the eventual ending of the current ring-fenced grant. I know that local government welcomes the shift to 100 per cent business rate retention. Including public health in its scope signals loud and clear that improving the public's health is a mainstream local government function, not an add-on. And I hope and believe this shift will further reinforce local approaches that look beyond the delivery of specific health services, and focus on the powerful alignment of opportunities to improve health, prosperity and quality of life for local people. Of course local authorities will retain statutory responsibilities for public health functions, including key services and a primary responsibility for taking action to improve health. Local accountability will need to continue to focus both on how specific duties are met and more broadly on local performance in improving health, including tackling inequalities.

Yes, there are challenges – but let's not lose sight of the opportunities. And one of those opportunities is the way public health is no longer seen as the domain of a few specialists but is being so much more widely embraced and owned. It's no longer public health – rather 'the public's health'. Yes, we still most definitely need the specialist workforce to lead and drive the agenda forward. I constantly hear examples of fantastic work, real impact and leadership by public health teams around the country.

I also hear from local authorities how much they value having public health colleagues in their organisations. This makes me feel optimistic for the future. Public health is at the heart of what local authorities are about, and we need specialists to lead this.

But the acknowledgement that there is a much wider workforce that contributes to improving and protecting the public's health offers an exciting opportunity and I am sure there is more we can do. Making Every Contact Count (MECC) is a good example of this in practice. A recent report by the Royal Society for Public Health (RSPH) challenged us to think even wider – what about engaging groups that we may not have traditionally done in our endeavours – pharmacists already do quite a lot in this space – but what about hairdressers? I like this breadth of vision – a social movement for improving health.

If I had to identify one thing on my wish list it is that I think we need to shift the paradigm – for too long discussions have been focused on life expectancy, single conditions and a medical model. We need to think more about HEALTH expectancy. In other words, it is as much, if not more, about what people live with rather than what they die from. Maybe it's advancing years – but I don't want to live longer but more of those years in poor health.

This takes us into disability, quality of life and the real sense that health is so much more than the absence of disease. It highlights the importance of place and community as a focus for action, of considering the life course, and places a focus on both the wider determinants as well as individual behaviour and action. I know that this is the thinking by many colleagues at a local level, who, together with local authority and community colleagues are already taking action. To me it is at the heart of what improving the public's health is about – and it is what motivated me to enter public health, and still motivates me all these years later!

Closing the gap



Paul Najsarek

Chief Executive, London Borough of Ealing and SOLACE Representative

Political events over the last year have created a fresh opportunity for us to focus on how we narrow

the gap in outcomes between and within our communities. Interpreting the meaning of the EU Referendum is contested but there are striking correlations between measures of subjective and objective wellbeing inequality and areas of the country expressing most dissatisfaction with the direction of the country and economy.

If we add to this the reduction and ultimate elimination of the ring-fenced public health grant, this creates a strong impetus towards public health acting as a framework for commissioning outcomes across all our activity rather than a discrete service within the council with interests to defend and budgets to protect.

The conditions for achieving this are present in the good work being done in communities up and down the country. The challenge for us is to quicken the pace and scale of the shift in approach in all areas.

The features we need to encourage are:

- The use of public health and wellbeing inequality outcomes as the test of success of our local communities and economies.
- A 'one public service' approach to prioritisation of spend and activity across all partners – including health, police and skills.
- Using public health and wellbeing outcomes as a test of the strength of devolution deals and to evaluate their impact.
- Engaging residents and business in understanding how their behaviour impacts on outcomes.
- Considering health and wellbeing in all policies.

The core role of the public health workforce in this world is to ensure the sophisticated use of data to guide evidence based commissioning, providing a toolkit of evidence based interventions and evaluating the impact on outcomes and inequalities.

For all the challenges this is a great opportunity to complete the journey of public health after the move of responsibility to local government. This builds on the good work in councils and with partners over the last few years.

The prize of thriving early years for our children, improved incomes for the low paid, good quality work opportunities and high quality places is at the core of the local government mission.

May you live in interesting times?



Dr Andrew Furber
President, Association
Directors of Public Health

The apocryphal 'Chinese curse' of living in interesting times has certainly been the experience of DsPH over the last three years.

The core purpose of a DPH remains that of an independent advocate for the health of the population and leadership for its improvement and protection. At one level this is no different to when the role was first created in 1847.

However the some of the challenges have changed out of all recognition, as has our understanding and ability to address them.

The fundamental influences on our health remain our social circumstances. The last three years have provided an incredible opportunity to work with housing, economic development, education, planning and transport. These are the things that really have the potential to improve health over the longer term.

The move to local government has also allowed us to review all the services we commission and ensure they are effective and efficient. There are many examples of new service models delivering better outcomes at lower cost.

There is no doubt that the loss of over £500 million from the Public Health Grant has had a detrimental effect, especially when local government is already the part of the public sector most affected by austerity. The lack of investment in prevention and early intervention has been a failure of social policy over recent decades.

Unless this changes the human and financial costs of health and care services will continue to escalate.

Despite these challenges, the changes to public health over the last three years can be seen as an exemplar of public sector reform. The principles used and the skills required can be applied to other functions. Indeed many DsPH now have wider portfolios reflecting local priorities such as integrated commissioning, prevention and intelligence.

These changes present both opportunities and challenges to the public health workforce. There needs to be better recognition and support for the public health role of those in jobs such as housing officers or transport engineers. Public health specialists need to be developed to apply their skills beyond their comfort zone wherever there is the prospect of it resulting in improved health.

There is no silver bullet for England's main public health challenges, the immediate causes of which remain tobacco use, poor diet, physical inactivity and alcohol misuse. Each is driven by a complex web of socioeconomic circumstances. As the saying goes, for every complex problem there is an answer that is clear, simple, and wrong.

But with comprehensive strategies we are making a difference. Teenage conception rates have plummeted and youth smoking and drinking rates are lower than they've been for decades.

The challenge is now to break the generational cycle of disadvantage that drives health inequalities. There is growing evidence intervening in the first 1,000 days of a child's life can make a difference over their whole lifetime. Is there a better place to start?

The health of the people is the highest law



**Professor
John Middleton**
President, UK Faculty
of Public Health

No one should be in any doubt that the return of public health to local authorities was a historic move. The duty to improve the health of the people councils serve enshrines a principle going back over 2,000 years to Cicero: 'the health of the people is the highest law'. A motto 14 councils have displayed on their coats of arms. Councils as place shapers can create conditions for better health, through town planning, housing, environmental and regulatory services. Councils as service providers and commissioners can improve health through education, social care, community and leisure services.

The potential to use local legislation to move local health objectives is largely untapped. But this is theory; neither should anyone be under any illusion that this is easy. Public health has moved to local authorities at a time of unprecedented removal of powers and resources. Public health staff have moved from the relatively protected, centrally driven NHS to the 152 unitary authorities, different in their political colour, local culture and managerial delivery styles. It would be difficult to envisage a less favourable environment into which the new burden of public health could have been transfixed. And yet the best will, and are making it work. Many councils have seen the opportunity – the asset of public health and many DsPH are now rising to the challenge.

The best councils are looking at their total budgets and seeking to make all investment decisions for the best health impact. The best DsPH are performing as high level corporate directors holding wider portfolios relevant to the public's health.

The budget cuts announced in 2015 provoked criticism from the Health Select Committee, the LGA, the King's Fund and even NHS England. Demanding prevention to reduce pressure on the NHS and then cutting the budgets just don't go together. Local authorities and the public health community have been thrown into the same trenches together, and are firing in the same direction.

The UK Faculty of Public Health is the professional standards body for specialist public health. You would expect me to believe that public health considerations about the public's health should be central to what councils do, and you would expect me to advocate for the specialists we have trained and overseen in their development. I will assure you that we are standard setters, and therefore not apologists for inadequate performers. I believe local authorities have a right to expect people with our badge to be accomplished population health experts in command of the best evidence on what works, to inform and advise elected members and managers sensitively and persuasively about where to invest and where to disinvest, to save the most lives and add the most to quality of life. Where our members don't do this, tell us. Where they do it, tell the world!

For my part, I would like to work with councils in the spirit of cooperation of partnership as I have done all my professional life. I would like to help councils deliver the full range of public health disciplines – that means not just the vitally important health improvement and healthy public policy role, but also health protection and advice to the local NHS on health care related public health. Councils also need to develop their knowledge and capacity as testbeds and users of public health research.

I recognise there are many councils are doing these but we have a duty to ensure there is at least a minimum standard across all councils – many public health problems do not respect council boundaries so it's no good if your council is great at tackling TB, or dealing with illicit drugs, if your neighbours are not. In the next few years we face an uncertain future, local authorities facing yet more cuts, and perhaps more worryingly, a failure by central government to value and appreciate their role...an expectation of offloading responsibilities but not supporting and funding then blaming local government for the failures. In addition, we are seeing public health outcomes getting worse in many areas and for some conditions, for example epidemic sexually transmitted disease, a spiralling of drug related deaths, a fall in smoking quit attempts and the concerns over loss of life expectancy in the over 85s.

It is my privilege and responsibility to lead the specialist public health community, but it is also my aspiration and expectation that we will improve the public's health. Local authorities are central to this and I plan to work with you to reassert all our roles as champions for the public's health.

Embedding improved health and wellbeing



Shirley Cramer

Chief Executive, Royal Society of Public Health

As the old Chinese curse says, 'may you live in interesting times' and you can't help but think that 2017 falls well into the

category of 'interesting times' as trying to forecast the future is akin to taking a firm hold of jelly. Just when you feel some certainty, it seems to slip out of your grasp. However, we can assume that dealing with the fallout from Brexit will claim the time and energy of politicians on all sides in Westminster as well as those with a different agenda in the devolved nations. For public health it is vital that we continue to keep a UK perspective as the challenges for the public's health are aligned, even if the structures and politics that govern them, are not. We must also ensure that public health has a position on how to protect and improve health and wellbeing in any future trade and investment agreements.

The Health Select Committee report looking at how public health has fared in local authorities since 2013 has provided an important benchmark and is, at the very least, a good place to start when thinking about 2017. The good news is that there was a clear consensus from all stakeholders giving or submitting evidence to the committee, that making the public's health the responsibility of local authorities was the right thing to do. It was encouraging too that there were so many great examples of effective and innovative public health interventions in communities across the country despite the disinvestment in funding and the very concerning cuts in core services.

I heard Dr Tim Ferris from Massachusetts General Hospital talking about how they had effected transformation in his hospital and health system and he was very clear that if you want to develop new ways of operating and effect positive change, you need to 'invest to save'. He showed that by taking a small amount of money from the budget to do things differently (1 per cent) they were able build a more effective system that has provided significant savings. A major challenge for all of us is to argue more persuasively that investing in prevention and doing things differently will not only be better for individuals and families but also will create substantial savings to our overloaded health and care system.

With the STPs, the vanguards and the focus on regional and localism, 2017 should see a greater and much-needed focus on community based support, prevention and tackling the social determinants of health. Strong public health and local authority leadership will be needed throughout the UK to ensure that bridging the health inequalities gap is a priority. Innovation should be allowed to flourish and our tolerance of risk should be increased as we need to understand what is going to work well and why.

This is the year that improving the health and wellbeing of our citizens should be the 'golden thread' running through the planning for the transition to the new funding regime for local authorities. Embedding improved health and wellbeing into the framework for spending and accountability in the new era of business rates retention will be critical for the future of the public's health as will ensuring that citizen wellbeing is included in all policies.

During this year we will see the wider workforce for the public's health, those individuals who have the 'ability or opportunity to improve and protect health', mobilise to support their local communities. Firefighters, housing officers, leisure services, allied health professionals and pharmacy amongst many others, will join the prevention workforce with skills, increased confidence and enthusiasm.

We should be optimistic about the implementation of the sugar levy and the reformulation of high sugar products which could mean, at least, a halt to the increase in the prevalence of obesity, if not a fall in the next few years. The standardised packaging of cigarettes with their lurid images will continue the downward slide of tobacco sales as will the use of nicotine products to support quitting. Let us hope that 2017 is also the year that we act on climate change and air quality. The evidence is clear about the health risks and enacting small changes can make a big difference in the long run.

With all the challenges (and a few opportunities) that face us this year, there is no doubt that working together in a collaborative way to find solutions will give us the best results, so for the twitterati, #togetherwecan.

Are we any closer to a mature public health system?



David Buck
Senior Fellow,
The King's Fund

The title is a reprise of the essay I am revisiting from two years ago. Then the strapline was 'Moving towards a more mature public health system'. Looking back, was my crystal ball clear or clouded? Well, some things I was excited about never happened, or simply fizzled out. For example, does anyone remember the damp squib of the health premium? But there have also been some big achievements, including the transfer of responsibilities and funding for younger children's health.

One of the things I was particularly looking forward to was seeing how councils would innovate on public health, especially. Another thing it is easy to forget was that around a third of areas received windfall gains from the reforms, up a fifth over two years against their local PCT spending baselines. Frankly, despite lots of reported innovation, including in the raft of LGA case study reports, I haven't seen a convincing analysis of how local areas turned this windfall into significant improvements in services or outcomes for citizens. Such an analysis is long overdue. This is doubly disappointing, given we are in a very different financial place and the practical evidence of how local public health teams have improved outcomes for the better will be needed as we head into a future where the Department of Health (DH) grant will be replaced by retained business rates.

In my view, there are strong arguments for retaining the grant, or at least aspects of it, and you can look on The King's Fund's website for the details on that. But the decision has been taken and the future of public health locally will increasingly rely on strong leaders for public health. That will need strong leadership from DsPH and I have been impressed by many who have already taken on the challenge of bending the curve on the whole of local government spend to maximise the population health impact, not relying on the grant alone.

But they need to be supported to do it, from the LGA and others, and we need to ensure that the welcome increase in transparency about spending and outcomes that came with the public health reforms is not lost with the shift to business rates. Transparency remains a necessary condition that has to underpin the local public health system. But it is not sufficient. As public health becomes more embedded in local government's everyday workings there needs to be a fundamental look at accountability. How do we define failure, as well as improvement and success, in a system that is more about outcomes than about specific services? Who gets to make those decisions, and who is accountable to who? These are questions I was left asking at the tail-end of my essay two years ago and I am no nearer to knowing the answers. On that score, at least, we still have a long way to go to a mature public health system.

A provider perspective: what's been happening to sexual health and HIV?



**Professor
Jane Anderson**
Director of the Centre
for the Study of Sexual
Health and HIV, Homerton
Hospital

The transfer of responsibility for public health, and with it for sexual health, to local government ushered in a period of unprecedented change. HIV, sexual and reproductive health which are inextricably intertwined now have multiple commissioners and providers throughout the pathway, often with differing strategic approaches, accountability mechanisms, and cultures. It's been confusing – a lack of clarity about responsibilities was exemplified by recent arguments over NHS England's ability to commission HIV pre-exposure prophylaxis (PrEP), a point eventually decided by the courts. In some areas competitive tendering has hindered commissioner-provider dialogue and providers who were previously collaborators have found themselves in competition. Dealing with the consequences of the new arrangements has been demanding for everyone involved.

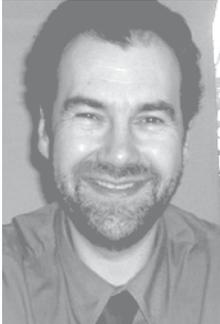
And challenges to good sexual health continue. Changing health behaviours, sexualised drug use and increasing rates of antibiotic resistance need new approaches. New HIV infections continue as does HIV associated stigma. Meeting the increasingly complex needs of growing numbers of people with HIV, particularly those who are ageing, is ever more important. And all this is taking place against a backcloth of cuts in public health funding and more widespread financial austerity.

In today's climate of scarce and dwindling resources we need to implement what we know works, maximise existing strengths and explore new ways to do more for less. Things that work include sex and relationships education – something that is not yet available to every child in every school. Easy access to condoms reduces STIs and HIV. Putting NICE HIV testing guidelines into practice will reduce late and undiagnosed HIV infection. Prevention interventions including antiretroviral drugs and behaviour change will make the difference for those who are HIV negative. There is a wealth of expertise amongst clinicians and service providers that is yet to be fully harnessed. Using online methods to deliver diagnostic tests is proving to be a success.

None of this is easy in a landscape of fragmented commissioning and organisational change, and is made even tougher when investment in one part of the system delivers savings elsewhere. Success requires whole system approaches in which commissioners, providers and service users work together develop joined up, strategically aligned plans to meet population needs. This could be a good fit with STPs as potential vehicles for joining up the system. However so far there is little evidence that sexual health and HIV are being included in plans. Sharing learning of what works across the country is immensely helpful for commissioners and service providers alike.

And the rewards for getting it right? Good sexual health is far more than the absence of ill health – it is a marker of healthy, equitable and productive communities. Paying attention to sexual health is one of the most effective ways to enhance the physical and emotional wellbeing of individuals, families, and society.

Decisions about the future are made today



Paul Lincoln
Chief Executive,
UK Health Forum

It was right to transfer the NHS's public health functions to local government but clearly very unfortunate timing given that local authorities have been subject to unsustainable budget reductions and economic restrictions.

Local government is unarguably uniquely placed and able to positively tackle the wider determinants of health and wellbeing at local level in ways that the NHS could never undertake.

The NHS and local authorities face major funding crises. The prognosis will only worsen unless there is a radical strategic upgrade in public health and social care. Public health interventions can massively reduce and shape avoidable demands on health and social care. The latest Office of Budget Responsibility fiscal sustainability reports on the NHS are grim reading. Unfortunately, their analysis of the future scenarios does not factor in the very high return on investment analyses that many public health interventions can yield.

There are new challenges to the public's health such as air pollution that were foreseen but ignored or kicked into the 'deal with in the future' box. The failure to address these issues early on and at source will cost many lives and is at great economic cost to individuals and the state. Often the most cost effective public health solutions are at little or no cost to the State but challenge the status quo or vested and ideological interests.

The specialist expert public health workforce is fundamental to informing decisions about the future that need to be made today and not left to the future. Their knowledge on the social, economic and environmental causes of ill health and health and wellbeing should be a component part of the assessment of everything the local authority does and plans to do. Without that catalytic workforce the health of the population and future generations is at risk. This workforce needs to act at a system changing level and have the analytical capabilities to inform local political and executive leadership.

The reality is that most public health challenges are created by human actions or inaction. Public health is uniquely placed to unite and add real value to what the local authority does and is key to sustainable development and prosperity.

The country faces a rising tide of need



**Councillor
Richard Kemp**
Vice Chair,
LGA Community
Wellbeing Board

As we mark four years since public health transferred back to local government, there can be no doubt that cuts to local government have hit hard at everything that a council does, never mind the specific and substantial cuts to public health.

In general terms, I have always thought that everything that a council does contributes to good or bad public health outcomes. We provide parks, libraries and community centres. We plan communities and transport to service them. All those services and facilities are vital in ensuring the physical and mental health of our communities. All of them are under threat with councils like my own in Liverpool effectively having a 50 per cent cut in our net budget.

On top of that we have had huge cuts in the public health budget since it came over to us. Imaginative and innovative as we are, we cannot provide the same level of service given cuts of this magnitude. This is at a time when the hospital based part of the NHS (which accounts for 90 per cent of the NHS budget) is absolutely stressed.

Accounts are legion of A&E trolley parks and delayed or cancelled operations. The demand goes out for more money for the NHS. Local government does not believe that that alone is the answer. The chief executive of NHS England agrees with us and suggests if he had more money he would put it into social care.

That is absolutely the right decision. Firstly, we need to stop people becoming ill. One in five children in Year 6 is obese. Most people will reach a retirement age of 68 with a disability. Sick days cost our economy £14 billion a year.

The country faces a rising tide of need, as people live longer but spend more of those years in ill-health, largely because of preventable chronic diseases. Surely the mark of a civilised society is to stop people becoming ill rather than just to make them better. It has been estimated that every £1 spent on public health saves £15 in the health service over the next few years.

Cuts in this budget are penny wise, pound foolish. Secondly, at the other end we have some hospital trusts where up to 30 per cent of beds are occupied by people with no clinical or medical need. We need to get them out of hospital either into their own home, which they would prefer, or into residential care homes on a medium or long-term basis. Local government is doing what it can. Proportionately it is spending more on social care and health than ever before. But given the scale both of the cuts and the increasing demand, especially from the frail elderly, means that we just cannot cope. As a sector at the LGA we work cross party and work for our communities as a whole.

When we ask for more money for the services that we provide this is not because we are undertaking some sort of 'grab for cash'. There is a general acceptance that by using the council as the principal mechanism for improving the health system in our communities there could be rapid and relatively cheap ways provided which would tackle the NHS' problems.

We know our patches and their weaknesses and opportunities. We know who our key players are. We are responsible for the joint strategic needs assessments and for HWBs. We don't look after our own interests but seek to pull everything together in our communities. Give local government and our partners the resources we need and we can ensure that NHS stresses are dealt with and crucially people have a better life from birth to death as we give them more proactive intervention within the communities where they belong.



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