People, Partnerships, Progress: The future of health and wellbeing in the North East

On 30 October the Association of North East Councils (ANEC) hosted "People, Partnerships, Progress", a conference on health and wellbeing in the North East.

The event marked 18 months since responsibility for public health has been handed to local authorities and acknowledged some of the key challenges that have been overcome so far.

The main focus of the conference was on the challenges yet to be tackled, however. These include regional inequalities, integration of services, and embracing the full of range of factors that determine health and wellbeing in our communities.

This report details the issues discussed and the contrasting viewpoints raised at the conference. It also outlines key challenges for local government, accompanied by some significant asks of central government to help move this agenda forwards.

Key points:

- Public health is far more wide-ranging than just the NHS. We should be minimising poor health in the first place and reducing the demand on hospitals.
- Good health and wellbeing is a product of environment, lifestyle and a raft of socio-economic determinants.
- Socio-economic inequalities persist, particularly in regions like the North East, and lead to drastic health inequalities that need to be addressed.
- The common risk factors of poor health are well known, and are amenable to action.
- The issue is not always a lack of money, but how it is spent. More powers need to be granted to combine budgets and make intelligent, local decisions about how they are used.
- Local government has demonstrated the improvements that can be made through leadership and coordinated action at the local level. This is particularly true in the North East, one recent example being the success of regional campaigns to reduce smoking prevalence.

Duncan Selbie, Chief Executive of Public Health England

The first presentation of the day was given by Duncan Selbie, Chief Executive of Public Health England.

Duncan warned against conflating health with the NHS, as this is a common misconception in national debate. Actual healthcare services make a marginal difference to length and quality of life, contributing to around 20% of good health outcomes. Focus on the NHS has been about supply, but we need to tackle prevention and demand reduction.

Duncan argued that the important drivers of good health lie outside the health service: jobs, homes and friends. He emphasized that a good start to life is the most important thing to get right.

Inward investment and economic prosperity are vital starting points. Without these it's an uphill struggle and reducing inequality in terms of health will be difficult. Duncan praised the work that has been done in the North East, given the differences with the rest of the country in terms of life expectancy and other factors of poor health.

The solution is not just about money. We don't need a bigger Better Care Fund, for example, just more intelligence in how we spend the money that we do have. We are in a very important moment, with integration of health and social care high on the agenda and how we provide services is incredibly important.

The common risk factors for poor health are well known and amenable to action:

1) Tobacco – We need to tackle this when people are young. The North East is a world leader in this regard as the 12 councils have come together and reduced smoking by a third.
2) Hypertension - 60% of dementia is actually blood pressure related.
3) Poor diet, especially sugar.
4) Lack of exercise.
5) Alcohol.

The leadership for intelligent spending of the public health budget should lie with local government, in partnership with CCGs. But it is important to ensure that we also devolve power to communities and people.

The challenge for Public Health England is to strengthen advocacy across government, because partnerships are the key to progress. We need to get better at telling our story and highlighting what can be done if we look at the real determinants of health in order to make the right choices.

Councillor David Sparks, Chair, Local Government Association

Chair of the Local Government Association, Cllr David Sparks, started by saying that when we talk about wealth we have to include health in the discussion. It is clear, he argued, that better distribution of wealth would lead to the narrowing of health inequalities. These are a big part of the north south divide.

Cllr Sparks praised the North East, arguing that it has been leading by example, building excellent partnerships through ANEC. The more early intervention work we can do, the more we can save in health and social care. Anti-smoking campaigns in schools save £15 for every £1 spent, while other campaigns, such as reducing salt in food and promoting exercise saves huge amounts of money, and saves even more for the NHS upstream. He also argued that we can help millions of obese children by reinvesting 1/5 of VAT from sugary drinks and sweets and junk food.

Health and Wellbeing boards have huge potential to act as lead commissioner to address local need. Helping people live independently at home could save £3.5 billion a year from social care budgets. But to do this, Cllr Sparks argued, we need a larger better care fund and a separate transformation fund, to move from acute to community services and home care. This will be crucial as chronic conditions like asthma become more common. They are set to increase by 1/3.

As well as a larger Better Care Fund, we also need an Innovation Fund, to help us build on the work the Health and Wellbeing Boards have begun. Adapting these health and social care systems is going to be costly and there will be lots of difficult arguments to make. But the costs of inactivity are far higher in the long term.

It is vital, however, for all of this to work effectively, that we start and finish with community. Community is the building block that gives councillors and local government the focus and the credibility. We have to always think about community when we decide how to deliver services and how to distribute resources.

Panel Discussion

Discussants: Cllr Nick Forbes, Leader, Newcastle City Council; Richard Barker, North of England Regional Director, NHS England; Anna Lynch, Director of Public Health, Durham County Council; Clare Bambra, Professor of Public Health Geography, Durham University; Duncan Selbie, Chief Executive, Public Health England.

Nick Forbes talked about the importance of embedding public health in local government, so that it is central to what councils do. He said councils inherited a set of clinical functions, which they are now integrating into a broader context. This allows more intelligent interventions, so we don't just look at smoking cessation but overall tobacco control. Rather than promoting exercise for individuals we design public space to encourage and make it easier for people to exercise.

The change in public health responsibility closely followed the abolition of regional structures. It is important that these have been replaced by collaboration.

There is a big challenge, however, around how effective we can continue to be if we are limited by funding restrictions.

Richard Barker argued that we need a long term approach. We need greater productivity, but crucially change in the demand profile through better prevention and better care.

We have money but it's in the wrong places, he argued. Higher hospitalisation rates in the North East cost the region around £300m annually. That is money that could be used more effectively elsewhere.

Anna Lynch highlighted the diversity and inequality within County Durham, which makes local knowledge incredibly important. We have to ask whether people can make healthy choices in poorer communities and look at how we might help them to do so.

Health inequalities are pervasive, persistent and inter-generational, however, which makes the situation more complex, Anna said. This is not about any one issue that we can fix. Economic inequality is the real key.

Clare Bambra commented on the "Due North" report into health inequality between the North and South. She argued that there is a very strong case for devolution of health as it is the only real way to free us up to support better health intelligently.

David Hambleton argued that we have to start with relationships, between councils, CCGs, other public bodies, and communities. We should not underestimate the time it takes to build these relationships and how important they are.

In terms of interventions, David argued that we have to change long-term behaviour. This has to start with personal conversations, at the family and community level.

Duncan Selbie agreed with the other panelists, commenting that health needs to be relevant and meaningful to people. Poorer people have narrower choices, though they are still choices. The task is to widen those choices and reach out to people? Local government can do that to some extent, but the third sector can do it even better.

Responding to questions Richard Barker argued that we need to change the language around public health in order to improve the dialogue with hospitals and make sure that this agenda resonates with them – arguably it doesn't at the moment.

Nick Forbes questioned whether health and wellbeing boards have the capacity to take on this dialogue. There is a lot of pressure on them to take on this leadership role for which they are not resourced.

But, he warned, the last thing we need is more re-organisation. The structure is less important than the ambition and we are moving in the right direction.

Duncan Selbie agreed, referring to three fixed points, which will survive any government or restructure:

1) General practice is the engine and the point of interaction for public.
2) Local government does most for wider determinants of health.
3) Hospitals. The NHS is much loved but what does it have the capacity to do?

Anna Lynch argued that health is everyone's responsibility, not just professionals. She emphasised the importance of making every contact count towards public health, with all organisations in all sectors. For example, we should be working with schools to get their support in promoting public health.

She also emphasised the huge impact that loneliness can have on health, a point supported by Clare Bambra, who argued that it can have similar effects on life expectancy to smoking, but does not make it on the list of big health issues.

Clare Bambra noted that education has a huge role to play in long-term health outcomes, but only if there are jobs for people to go on to when they leave school or college. Nick Forbes agreed, arguing that the health of our society depends on the type of society we have.

He also said that there is an issue with commissioning, which has different definitions for different people. It is often seen narrowly as a matter of procurement. But it is more holistic than that and there needs to be a better dialogue to open commissioning up as a discursive process.

Workshops

Workshops provided forums for more focussed discussion on 4 key themes: Useful evidence; health inequalities; integration; and public health.

Evidence

The session on evidence focussed on three key questions:

1. **What is useful evidence?** There is a range of types of evidence available to us, from 'pure' academic through to experiential. What is useful is relevant and practical to addressing the issue at hand i.e. 'what gets the job done'.
2. **How can evidence be turned into policy and practice?**. Evidence can be turned into practice by translating and brokering evidence through partnerships between those in academia, policy and practice.
3. **How can we make it happen?** Partnerships that can respond quickly to problems, that are coherent, and exist over the long-term are needed to ensure continuity. All sectors should be involved, though this will require increased training of the workforce to develop new skills.

Alyson Learmonth argued that health and social care systems are complex and it is challenging to use what we know effectively as these have been changing quite quickly. It is really important to be able to scan the horizon clearly because there are simple things that can have a huge impact, which should be done as early as possible.

Part of the process of putting policy into practice, Alyson argued, should be about good dialogue. This means strong relationships and open forums between government, the public and academia.

Phillip Edwards, Institute for Local Governance, argued that we have lots of data and evidence, but there is conflict over what aspects we decide to investigate in detail. ILG does large and small projects with partners to help identify some of these. These are collaborative, both in terms of research design and outputs.

Good evidence and analysis both come from within local government, but shrinking resources mean that partnerships and flexibility are increasingly important.

Rosemary Rushmer, Teesside University, posed the question: why is some evidence not useful? A lot of evidence is robust academically but not translatable into practice because it emerges from a very specific context and addresses specific issues.

Dr. Stephen Stericker, National Institute for Health and Care Excellence, argued that there is a real challenge around getting evidence informed recommendations implemented. Very often the evidence is there, but lacks the frameworks or support to put it into practice effectively and at scale. The important question that we need to be asking, Stephen argued, is what does good *implementation* look like?

Health inequalities

The three key points from the workshop on health inequalities were:

1. **Uneven economic development**, with regards to a North/South divide. The most deprived areas should be targeted so they do not see inequalities in health widen even further.
2. **Devolution of control** regionally and through communities. The importance of volunteers was considered a central point here. The wider community benefits of devolution were debated, including drawing on assets already present in communities, and the issue of power was often raised.
3. **The 'poverty premium'** and how this impacts upon people disproportionately in the North. Fuel poverty was considered particularly important here, as was the role of the voluntary sector.

Prof. Paul Johnstone noted that since the recession health inequalities have been increasing and that the economic upturn is actually exacerbating the inequalities within the country. This led to the 'Due North' report, which analysed inequalities of poverty, power, resources, access to good housing, good jobs, food, and industry, among other things. Health inequalities are not inevitable, but have been reduced in many parts of the world.

Anna Lynch argued that it is shocking that such a north/ south divide persists and we in the north have to stand up and be counted because no one is going to do it for us. She described how local government had a very important place on the Due North panel to give a practical perspective and to ensure that the findings were relevant and would address real problems on the ground.

Jenny Saunders, from National Energy Action described the huge effects that poor energy and heating have on health and wellbeing.

To ensure an intelligent, joined up approach there needs to be a better link between health professionals, local government and what actually goes on in people's homes. Simple mechanisms could make this happen.

Sally Young, Newcastle CVS, commented on the huge voluntary sector in the North East, with around 20,000 organisations and a lot of assets. Future policy and activity should recognise this, as Duncan Selbie argued, by devolving power to the town hall and beyond in order to get communities involved.

Voluntary and charity organisations have capacity to make huge change but there has to be a leap of faith. Commissioners should try to do something different and give up a small amount of income elsewhere in the public sector to involve the voluntary sector. There are plenty of outstanding examples in the North East of voluntary and community involvement.

Integration

It seems as though the argument for integration of health and care services is obvious, but there are big challenges around language and method of engagement, among other things. We must remember to talk about integration so that it is about people, not just about structures and control. Personal and pooled budgets could have a huge value but only discussion and dialogue will take us forwards, particularly with regard to hospitals.

Karen Taylor, from Deloitte, noted that there has been a great deal of success so far as people are dying older. There are attendant problems with this success, however, as older people with multiple morbidities take up 75% of the NHS budget.

Karen also outlined the findings of recent Deloitte reports that investigate end of life care and care for the elderly. These assert the importance of communities and charities, as well as the public sector, while emphasising the potentially transformative role of technology. Improving understanding of the needs and wishes of elderly people, as well as enabling greater training and skills to deliver the necessary care, has to be a component of future health provision in our communities.

Caroline Bosdet, LGA, argued that the democratic legitimacy of Health and Well Being Boards has a primary role in implementing the recommendations of the Barker Commission. She outlined the LGA's100 Days programme, which sets out the LGA's asks for the new Government following the next election.

The LGA carried out "Great Expectations" a review of the health and wellbeing system improvement programme, with Shared Intelligence. She recognized that it is a complex and challenging system but noted that local government is getting on with making it work in innovative ways.

Governance will become more of an issue in the future. The LGA is focused on supporting leadership with peer challenge and support. There is a future vision for HWBs that has ambition, clarity of purpose and clear direction.

Dr. David Hambleton, Chief Executive of South Tyneside Clinical Commissioning Group gave an overview of the work they have been doing over the past few years and the lessons they have learnt along the way. He gave particular attention to South Tyneside's status as one of the 14 "integration pioneers" following their work on self-help and self-management of care.

David argued that the focus had to be on relationships from the beginning. Coterminosity between the council and the CCG helps in this regard.

South Tyneside has an asset-based approach, which is about empowering people to use available resources to take care of themselves. They key for professionals is learning not to jump in but to step back and trust people. It is vital to understand what the key enablers and barriers are, and to ensure patients stay at the core of integration work, especially when implementing new technologies.

Public Health

The public health workshop focused on the breadth of the agenda. It identified areas for collaboration, including strategic working with voluntary and third sector orgnanisations, to give voice and resource. Possible collaboration across sectors, especially housing and environment, was also discussed.

It was emphasised that public health should not be confined to a department but be embedded across a whole place and should look for opportunities to increase social value. It was also argued that we need clear measures of outcome.

Key points from the workshop were:

1) **A common language needs to be developed** to facilitate collaboration, including the development of common objectives and outcomes. This language should be inclusive and flexible enough to be used by different professionals as well as elected members, third sector and the public.
2) **The environment that decisions are made in** is important, both for the individual and for organisations and agencies. This can have an influence on the context of activities such as commissioning, provision, community engagement and partnerships.

3) **The wider social value** of interventions needs to be accounted for. This will involve different measures of outcome.

Colin Shevills noted that so far there has been lots of discussion about choices but not much about the environment in which those choices are made. Smoking and alcohol, for example, contribute to early death but are taken up more in those areas that already suffer from deprivation and economic inequality.

Tom Ross outlined ways that the TUC is working with business to review and improve the health and wellbeing of workers. These include an award scheme for better health at work. In a review of staff at BAE systems, more than 80 out of the 90 participants needed medical treatment and 4 were diagnosed with prostate cancer. There is clearly a lot that can be done in the workplace.

Dr David Pencheon spoke about a tool kit for Health and Wellbeing Boards to help embed sustainability in as much of their work as they can. This can often be done almost invisibly. This allows us to quantify the environmental impact, as well as savings and the social value produced. There are lots of good examples of how we can embed sustainability in health strategies.

Roberta Marshall discussed the importance of the social environment and of getting upstream of any potential problems, to influence them before they become acute. She also emphasised the importance of considering sustainability with health.

There was discussion about whether the continued ring-fencing of public health budgets was necessary or desirable. It was also seen as vital to keep mental health in the conversation. We also have to recognise that engaging with communities takes time and money, putting greater emphasis on the need for long term planning and spending.

Andy Burnham

Andy Burnham, Shadow Health Secretary, outlined plans for devolving power over combined health and social care budgets, to redress regional imbalances and inequalities. He emphasised the importance of working with existing structures as well as the prominent and exciting role for local government.

He began by noting that resistance to London centric policy is growing and growing.

Households in the 10 most deprived boroughs in the country have seen a 16 times greater reduction in spending power than 10 least deprived. At the same time, the looked after children budget is the same per household in Newcastle as it is in Wokingham. We have a similar problem in health.

We need to be vigilant about what happens to health allocation for the North East over the next few months, as it has been significantly reduced recently. There is a new spending formula in place, which has put many CCGs technically over budget and over target spend. According to the new formula Sunderland is over funded by 10%.

Therefore, we need to look at devolving power. However, an English parliament would simply entrench a permanent dominance of the South over the North, and policy would become even more London centric. The solution lies in regional devolution and that debate needs to be refreshed.

Local government in the North East has been leading the way, forging a partnership with a range of organisations across the region, quite unlike other areas. Life expectancy has been rising faster here than anywhere else outside of London due to the boldness and the vision and innovative programmes on tobacco, alcohol, and exercise. There is evidence that with vision, cooperation, and combined voice, we can achieve really big things.

The time has come to pool resources, get rid of silos, and abandon territorial arguments and institutional loyalties.

Westminster and the media sees the NHS as an island, separate from other service areas. This has dangerous consequences because it is based on politics, not good policy. They are intertwined and we should not raid social care budget to pay for the NHS. Collapse in social care exacerbates crisis in the NHS – it is the biggest driver of A&E admissions. We have to recognise that the pressure is backing up through the system.

So we need fundamental reform where health and social care are paid for from a single budget with the mission of caring for the whole person. And this could be addressed through a single local authority fund to commission for the whole person, their physical, mental and social care.

Andy Burnham was keen to stress that he is not talking about wholesale restructuring or reorganisation if Labour get in to government next year, but working with the organisations they inherit. Health and Wellbeing Boards have a really positive role to play, for example.

He would introduce a single budget, administered locally, and develop a year of care tariff to provide wrap around care for a year following discharge from hospital. This would provide an incentive to build a single team around one person in their own home.

Devolution creates the conditions to link health with housing, planning, transport and all the wider factors that feed in to good health. This would be a much more ambitious approach where we start to commission for the health and wellbeing of the whole population.

Indeed this becomes the primary function of local government and encourages local government to be thinking more expansively and positively. It is a new future for local government, with councils as champions of public health.

But it is important for central government to return the trust in local government and give councillors the tools to do the job. This is devolution that does not bypass local government but embraces it.

Asked how locality-based action could be squared with the public's dislike of a 'postcode lottery', Mr Burnham said that Parliament should decide **what** should be provided, with clear rights for patients, and localities should decide **how** it should be delivered. But they must work through the 'preferred provider' model.

Comment

It was encouraging to see how practical most of the discussions that took place at the conference were. Though the scale of the challenges was well understood, there was a strong focus on how these might be met through collaboration, local and intelligent allocation of resources, and by extending the scope of the health debate beyond the NHS.

Local government is in a position to make a huge impact on the wider determinants of poor health. The recent track record of authorities in the North East has demonstrated the potential for leadership, co-ordination and practical action to tackle entrenched problems such as tobacco and alcohol use.

But public health is greater than these specific campaigns. Duncan Selbie made the point that good health is largely a result of good homes, jobs, and friends. Increasing local control and allowing greater flexibility for pooling of budgets would help to target these wider factors in innovative ways.

Mr Burnham outlined a policy that would see local government coordinate local budgets and would approach health as a socially determined issue. This would mean the social care and health would be integrated, with public health playing an important role across all areas of local government activity.

As Duncan Selbie said, we are in a very important moment, with integration of health and social care high on the agenda and how we provide services is incredibly important.

Challenges for Local Government

Duncan Selbie began the discussion by saying that good public health is essentially about jobs, homes and friends. This defines a clear role for local government and we have seen some of the excellent work being done by authorities in the North East on some of these fronts.

This opens up some serious challenges for local government, however, and asks the sector to think about its position in a radically different way. It challenges us to think even more about places rather than processes, outcomes rather than structures, and relationships rather than services.

- There are few simple structural fixes to many of these problems, and more money is not the only solution. Meeting the challenges will require more intelligent spending of the money we do have, with a focus on collaboration and leadership of place.

- The challenge, and the opportunity, is there for local government to embody this new role, to innovate, and to define its more prominent and decisive position with regard to public health.

- But local government has to be in a financial position to do this and the wider question of resources going forward cannot and should not be avoided. Further austerity measures could profoundly affect the North East's ability to make the step change in outcomes for communities and individuals.

- Councils need to think about whether their organisational structures allow horizontal commissioning across health, social care and related areas such as housing, leisure and planning rather than vertical, service led commissioning.

Asks of Central Government

At the same time there are some significant demands on central government to make this possible at the local level.

- We need greater devolution of powers to existing local structures. It is vital that this applies to different levels of governance in different areas, with the flexibility to combine and recombine in ways that meet local need.

- This needs to be considered alongside the resources available to local government. We need a local government finance system that reflects need and deprivation, reversing the trend of recent years.

- Local government needs to have greater control of 'single pot' health budgets, and the ability to combine these with social care and other areas of spending. We also need fiscal devolution within the UK in order to help address the drastic North/South divide.

- The government needs to review the powers and resources of Health and Wellbeing Boards to ensure that they are able to drive integrated health and social care commissioning, without placing on them undue burdens that they have neither the resources nor the capacity to fulfil.

- The government needs to put in place a mechanism that allows authorities, groups of authorities and other partners to come forward with local or regional 'care deals' that set out how they wish to integrate health and social care services and the budgetary structures, statutory powers and income raising capacities they need to deliver on these.

- The future economic prosperity of the North East is critical to achieving better health outcomes for people and communities, as reflected in the Due North report.

Actions for ANEC

Working through its member authorities and with partners, ANEC has a key role in driving forward a North East strategy to reduce health inequalities:

- As part of its advocacy work in areas such as local government finance, economic growth, ANEC should continue to emphasise the impact that policies in all these areas have on health outcomes and their potential to reduce, or increase, health inequalities.

- ANEC should continue to pursue health issues through its own structures, such as the Leaders & Elected Mayors Group, the Health and Wellbeing Board Chairs Network, the member-led Task & Finish Group that has been set up to consider the impact of an ageing population, the commissioning of research on children's and young people's mental health and so on.

- In pursuing these issues, ANEC should give careful consideration to the recommendations of the Due North report and should press central government to act on those recommendations that apply to it.