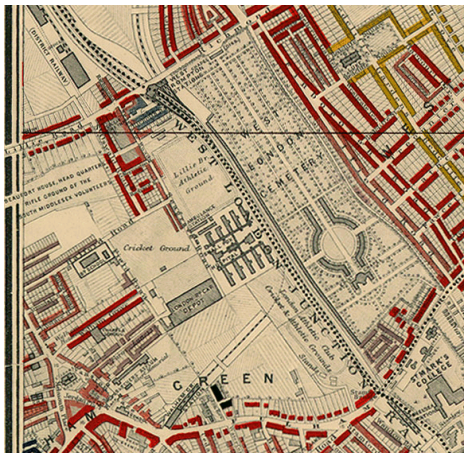
Executive Summary



When we think of mapping health onto place, the pioneering charts of Charles Booth, which sought to specify, with street-level accuracy, the actual working and living conditions of London's poor in the late 19th century, should come foremost to mind. As a piece of social cartography it can't be bettered. Poring through each chartered street, each colour-coded mark of sorrow, each mark of woe, the historical record of neighbourhood streets and alleys that encompassed individual lives and their wider sphere of community is laid out in a compelling visual totality.

Today with our incomparably vaster public and private knowledge infrastructure – whether NHS Digital's assets or Acorn consumer classification, and myriad data points on facets of a person's life far beyond anything any of Booth's Toynbee Hall researchers, armed with simple pen and pad, could have dreamt of, we should have the issue of place-based health licked.

Instead, and although its principles are now well-established and practiced, the full promise of a total place approach to area budgeting and comprehensive public service reformation in localities has faded, like one of Booth's maps. This is a pitiably missed opportunity. The Victorian era foundations on which today's local government structure was founded were struck in the series of parliamentary acts giving place a role and responsibility for public health and sanitation.

If the National Health Service remains, in Lord Lawson's memorable phrase, the closest thing the English people now have to a national religion, it's high time the general public started paying homage to the god of little things, the smaller deities which are public health and prevention.

But like all great religions, rationality must yield to faith and devotion - which is measured in what is given as tribute and the collection plate. This largesse hasn't always been the case. In 1953 the Treasury appointed the Guillebaud committee to find ways of constraining health spending. They reported two years later in 1955 that health spending was already naturally falling as a share of GDP with hospital building a fraction of the interwar rate.

At a time when ministers and officials are straining all means necessary to funnel billions of pounds from the health service's 70th anniversary budget boost into shovel-ready NHS schemes, there is a moral case for making population health and place investment count for the fullest amount possible. There is a case for putting place prosperity and local accountability to the forefront of a renewed drive for a health ecosystem that will be more than strong enough to meet the known challenges of demography, technology and the workplace revolution. Spending through the public health grant is up to four times as cost effective as NHS spending.

Local Practice is a case for place that is centred not around the need for

power transfer, but a localist case to liberate resources, assets and latent potential that exist within every community. It is a call to rationally manage limited resources and deploy data and new technology for the best results. It is a simple prescription to integrate agents of health and guardians of place at an appropriate level for the sake of delivering human-centred care to local populations through all stages of life.

Preventative care and the role of local services

Local government and public health

There is a symbiotic unity between our life and our environment. Inhabitants from the least deprived areas of England on average live for twenty years longer than those in the most deprived[1]. The health of a community is therefore inseparable from place and prosperity. Furthermore, the prosperity of place aggregates up to the benefit of the national economy. A well-balanced health and care system, one that allows local authorities to fulfil a statutory responsibility to public health, will be vital in tackling the Industrial Strategy's Grand Challenge of the ageing society. The case for place also extends to the health of our public finances, particularly those pertaining to the health service. It is in everyone's interest to foster conditions encouraging people to be healthier and more independent for longer and shift away from a treatment mindset. This chain of logic illuminates the reasoning for the deep-rooted historical public health duty assumed by local authorities since the 19th century.

Given the renewed focus on prevention, it is only natural that local authorities be leaders in the fight against public health challenges and how they manifest in communities. The last six years have shown us that tackling the myriad challenges facing our nation's health requires a holistic, collaborative and integrated approach. The Health and Social Care Act 2012 bolstered responsibilities and created the role of the Public Health Director in each upper tier authority. These directors play a key role in coordinating the council's approach to clinical commissioning, identifying needs assessments, and leading on local health protection specific to the community's needs. Despite this role, recently formalised but long-standing in practice, public health has not been spared the nine years of austerity which local government has borne the brunt of. It is estimated that between 2014/15 and 2019/20 the public health grant will have experienced a £700 million cut in real terms[2].

At the time of writing, the long-awaited Spending Review has not been timetabled. Instead we will see a one-year review, most likely along the prevailing fiscal trajectory. This means long-term funding for the public health grant is yet to be outlined, leaving local authorities unable to make forward budgetary decisions. If the government is serious about fixing the health and social care crisis, and shift efforts to prevention, cuts in public health funding need to be reversed immediately. Preventative care must be ring-fenced as a budget and considered alongside issues like schooling for disadvantaged children and care for the vulnerable elderly as a dynamic demographic pressure requiring special consideration.

Complex systems and preventative care

The need to go beyond linear clinical interventions has been recognised in academia through a complex systems model of public health. The complex systems approach recognises public health challenges as being multicausal in nature and doubts the effectiveness of measures designed around single interventions. While interventions on this scale might have minimal impact on the individual level, when aggregated on the population level, they will drive

1 Public Health Matters (2017) – Understanding health inequalities in England

2 Terrence Higgins Trust - Cuts to public health are cuts to the NHS: The need for continued investment in public health and prevention services

a much larger change. Taking this approach, interventions become a matter of the depth and reach of their impact on the overall population in question. Hertfordshire County Council was an early adopter in analysing health and social problems within the county using complex systems, taking a new way to decision-making rooted partly in scientific method and partly in pragmatism.[3] For example, tackling issues confronting the LGBTQ community requires addressing interventions on the individual and community level. This would involve interventions aimed at strengthening resilience on one hand, while implementing wider interventions that tackle stigma and build services which genuinely understand the community's concerns[4].

The Health, Exercise, Nutrition for the Really Young (HENRY) programme in Leeds has been a major success story in tackling childhood obesity through coordinated efforts of local services focused on delivering preventative measures. The foundational belief of the programme aligns with a complex systems approach, whereby simply providing isolated interventions on one level of the system is not enough. Childhood obesity, with all the challenges and solutions associated with it, needs to be viewed holistically. This is especially true for parents who face multiple challenges raising children in socioeconomic deprivation[5]. Grounded in its holistic approach, the programme entails interventions on all levels, centred around the child in its home and community environment, as well as the emotional wellbeing of the family. In 2019, Leeds drew national coverage[6] for being the first city in the UK to report decreased childhood obesity. Before this, Amsterdam had been the only city to report such a cut. The success in Leeds was only possible through a collaborative effort between the council's public health and children's services teams working together.

The Prevention Premium

In increasingly lean times, it is asking a lot of public health departments, which are already suffering from severely reduced grants, to engage in system-wide analysis when merely 'keeping the lights on' is becoming a realistic area of concern.

For this reason, we recommend that – in addition to the public health grant – local authorities with a public health duty be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions. The premium would be calculated based on demographic factors, reflecting the various different areas where deep, public health interventions, can be most effective. For illustrative purposes, we have selected some factors below to model where demand for preventative care interventions might be the highest in England. It is important to note that the indicators combined in our mapping do not form an exhaustive list and minsters and officials might well want to pick factors with a different emphasis in mind. For example, incidents of violent crime are not included in our mapping but may be considered to be a public health demand factor.

3 Localis Interview

4 Localis Interview

5 British Journal of Obesity (2015) - HENRY

6 The Guardian (2019) – Leeds becomes first UK city to lower its childhood obesity rate

Stage	Indicator	Definition	Source
Wider determinants	Unemployment rate	Percentage of the working age population who are claiming Jobseeker's Allowance plus those who claim Universal Credit and are required to seek work and be available for work.	Department for Work and Pensions
	NEETs	Percentage of 16-17 year olds not in education, employment or training or whose activity is not known.	Department for Education
	Children in low-income families	Percentage of children under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income	HM Revenue and Customs
	Over-65s	Percentage of the population over the age of 65	ONS mid-year population estimates
Lifestyle factors	Smoking prevalence	Prevalence of self-reported smokers	Annual Population Survey
	Childhood obesity	Prevalence of obesity (including severe obesity) of children in year 6	NHS Digital, National Child Measurement Programme
	Physical inactivity in adults	The number of respondents to the Active Lives Survey doing less than 30 minutes activity per weeks, as a percentage of total respondents aged over 19	Public Health England
	Substance abuse young people	Directly standardised rate of hospital admission for substance misuse, per 100,000 population aged 15-24	Local Authority Child Health Profiles/ Public Health England

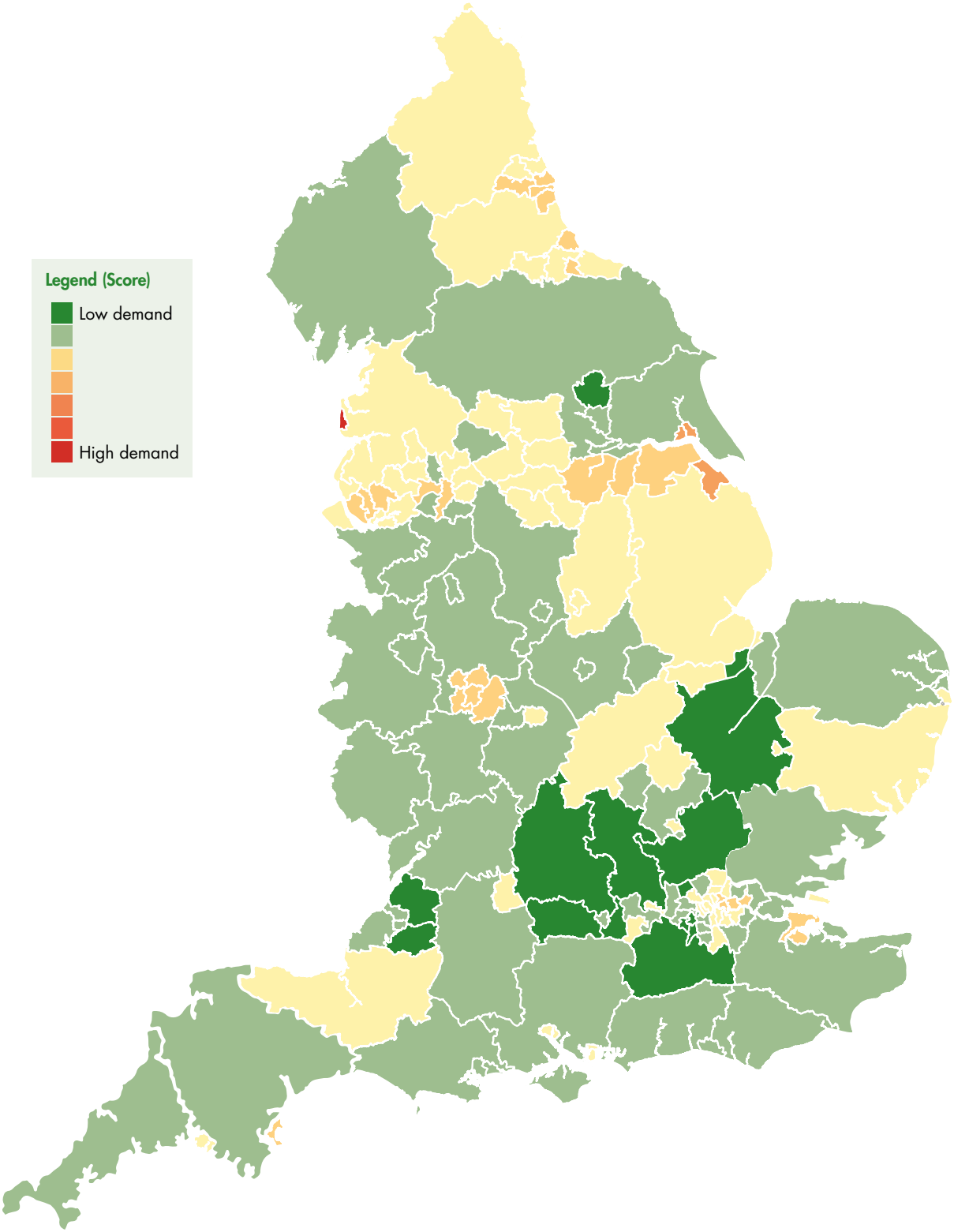
The role of place in the NHS

Consumer-led healthcare

The other side to the coin of the local authority role in public health is the self-responsibility of individuals to look after their own health. Government needs to become more serious about developing and encouraging consumer-led healthcare, focusing on methods for disease prevention and reducing demand by incentivising individuals to look after their own health better. The funding of programmes to promote and encourage consumer-led healthcare must critically consider the ongoing accruing value of such enterprises.

Currently, the major challenges are to:

Total preventative care demand score



- clearly demonstrate that capital investment leads to a significant reduction in future healthcare costs;
- identify funding streams that will support projects and posts;
- make the clear financial case for funding additional health economists capable of evaluating how demand-reduction affects NHS budgets.

The NHS will enjoy direct financial benefits from cost -reductions across a range of services, including in-patient episodes, pharmacy budgets, GP and outpatient appointments, district nurse services and service provision (pathology, physiotherapy, imaging, dietetics). Companies will reap the additional benefits of improving their productivity by developing a more stable and healthier workforce. Some charitable organisations operating within the healthcare sector have to divert much of their funding and resources to support individuals with chronic conditions developed as a result of poor lifestyle choices. We believe that there is a growing expectation that the consumable spending of charities should be allocated to the most deserving causes and that a drive to encourage self-managed healthcare will allow this.

Locally-delivered healthcare

Whilst the NHS gains huge strength from its networking capability, its facilities, and a standardised approach to working, one of the drawbacks of being a national health service is that for the most part the same standard and quality of service is expected to be delivered across all conditions, for all demographics and with all infrastructures. Currently, CCGs are tasked with commissioning and ensuring the delivery of healthcare locally. But is that really local? Since their initial establishment as 213 groups in 2013, over the past five years a process of rationalisation and mergers have occurred, such that by the end of this year there may be only 174 CCGs. Some of these, such as NHS Birmingham and Solihull CCG serve as many as 1.2 million patients. The greater the population that any CCG serves the less focused they can be on the needs of individual groups. Those needs can vary dramatically for patient groups with different ethnicities, religious faiths, socio-economic backgrounds as well as the unique rhythms and pressures of domestic and working lives. In addition, the workload and demand for services within any community can at times escalate unpredictably and increase the immediate pressure on the system.

It would be nice to think that the delivery of healthcare can always be a simple and smooth process, one by which people's normal condition can be maintained or defects rectified at times so they can get back on the road to health. The reality is very different and perhaps we should start to think of how we react to symptoms of serious disease more like we do for accident and emergency or epidemics. Because, as with natural disasters, damage to infrastructure and inevitably sometimes loss of life, are the knock-on effects for patients and health services that have to be addressed. We need to be able to divert resources quickly to address the problems of individuals, groups or communities in a way that might be appropriate in one area and not in another.

The role of NHS patient data in place-based health

The value of access to and use of data has long been demonstrated in the field of epidemiology, most notably for improving public health. Major advances have been made in infection control, including prevention of tuberculosis, smallpox and polio, and more recently human papilloma virus (HPV). Despite this major role that the NHS has played, since its inception it has failed dramatically to understand the full value of all the data that it generates and holds, and the information and knowledge that this yields. Currently there is no national solution

for locating and sharing electronic patient records[7], impeding the delivery of integrated care on all levels. Going forward, it is important to learn from the mistakes of the National Programme for IT (NPfIT). This was an earlier attempt at creating an IT infrastructure that connected general practitioners to hospitals across the country, and created electronic patient records. The biggest obstacle to this was the overreach of a 'centralised authority making top down decisions' for local organisations[8]. Key to the success of the above initiatives is a localist, grounded approach, and end user engagement.

The sharing of NHS patient data will continue to be viewed with more than a little suspicion by the general public with regards to its security and anonymity – especially once stored in data warehouses that are external to the NHS. If patient data is to be used across silos to improve care, it is of paramount importance to deal with the fears and trust of the general public, many of whom believe that allowing their medical information to be accessed means that it can be used nefariously. Government, NHS and local officials will need to work more closely with computer science departments at universities and other academic centres, as well as collaborate with the computer industry to develop systems for the storing, mining and analysis of such huge and sensitive databases.

Staffing the NHS and social care

Compounding the myriad issues facing the health economy discussed throughout this report is the worrying level of workforce vacancies it now routinely faces. Current estimates show that there are over 100,000 staff vacancies in the NHS, with little chance of training enough GPs and nurses to solve the current crisis[9]. At the moment, there are over 40,000 nursing posts vacant, which is one in nine posts[10]. This also includes a decline in the number of community health and mental health nurses. With social care, there are currently 1.5 million people working in the sector, but as the population increases and lives longer, in 15 years there will be a need for an extra one million carers[11]. This is before taking into consideration the similar levels of staff shortages in the NHS.

Heath and social care has always relied, to varying degrees, on immigration to fill staff shortages. Viewing this alongside the demographic changes occurring as a result of internal migration within the UK shows us how certain parts of the country rely on immigration more than others. Migrants make a unique contribution to the sector and are doing more than simply substituting for British labour; they are filling skills gaps the British working age population seem unwilling to plug. In all six English regions below the River Trent, non-domestic workers account for at least one in ten adult social care professionals. In London and the South East, workers from abroad provide 40 and 23 percent of social care staff respectively. Already, ongoing Brexit uncertainty has had an impact on the health and social care sector as more potential care workers are deterred from entering the UK jobs market.[12] Migration policy should not intensify the problem by placing obstacles in the way of recruiting the skills and labour the sector needs.

This involves a necessary boost of investment into the social care budget, which would allow for raising wages, and creating new opportunities and prospects for social workers.

7 NHS Digital (2018) – The National Record Locator Services

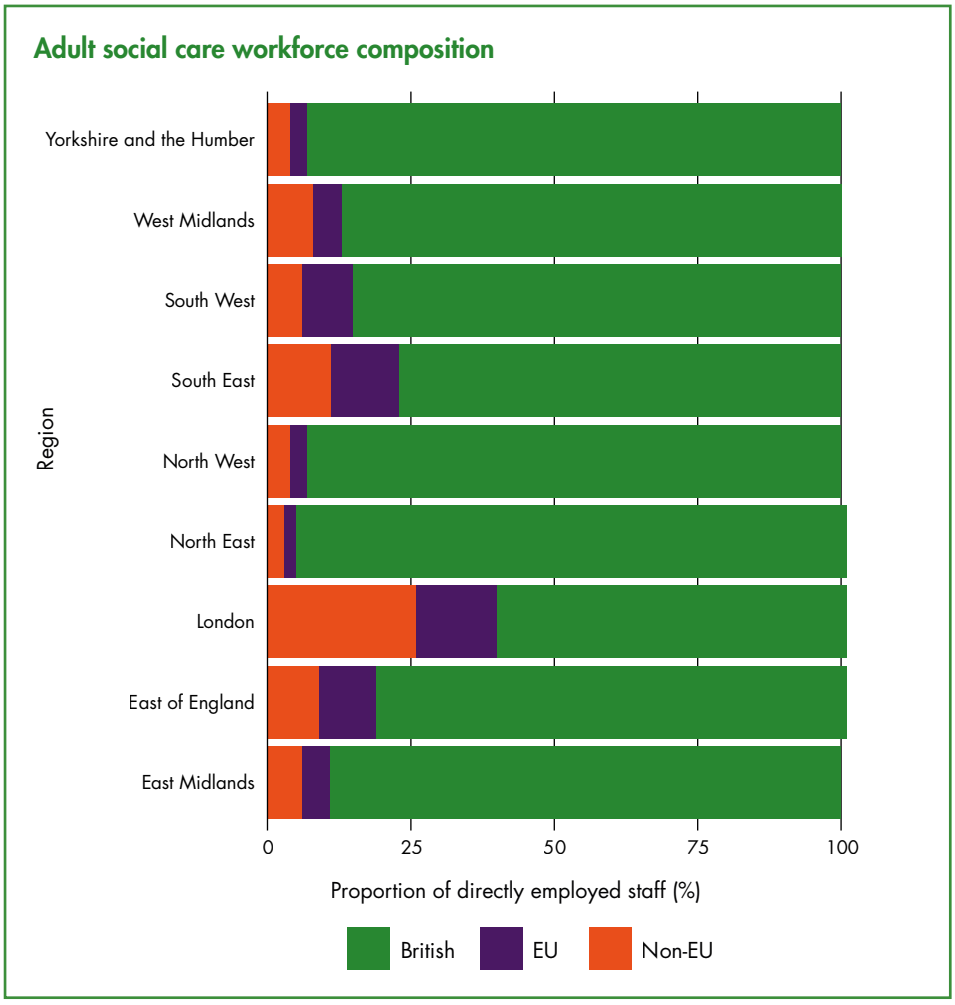
8 Justinia T (2017) – The UK's National Programme for IT: Why was it Dismantled?

9 BBC News (2019) – NHS has 'no chance of training enough staff'

10 The Health Foundation (2019) – A critical moment: NHS staffing trends, retention and attrition

11 Timewise – Social care crisis: How to keep the carers we have and attract a million new ones

12 Localis Interview



Source: SkillsForCare Workforce Intelligence.

A comprehensive immigration system that puts place-based needs first is essential post-Brexit. We propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area. Currently, individual NHS trusts are involved with extensively recruiting from abroad, and the government continues to ease visa restrictions to facilitate this[13]. The immigration element of health and social care staffing dovetails with the training of domestic workers when considered as an issue of decentralisation. In systems where local government has greater power over its destiny, approaches to immigration vary according to economic circumstance, demographics and institutional need to name just a few factors[14]. More local control over how visas for health professionals are distributed is a natural conclusion of this research.

13 ITV (2018) – NHS to recruit thousands more foreign doctors and nurses as visa cap lifted

14 Graeme Boushey and Adam Luedtke (2011) - Immigrants across the U.S. Federal Laboratory: Explaining State-Level Innovation in Immigration Policy

Recommendations

1. **We reiterate our call for local authorities to be given a coherent and comprehensive finance settlement that is fit for purpose.** One that is set on longer cycles of ten years, which would facilitate long term planning of the prevention agenda.
2. **In addition to the public health grant, upper tier local authorities should be provided with a Prevention Premium, modelled after the Pupil Premium grant for school funding, to help support the transition to public health delivery interlinked across all council functions and wider civil society actors and institutions.** The premium would be calculated based on demographic factors, reflecting two pinch points for public health. On the one hand, the rate at which the population is ageing and on the other the prevalence of child poverty.
3. **The new government should work toward releasing the Social Care Funding Green Paper at the earliest convenience, the paper should contain guidance on the joining-up of services to create holistic public health strategies as a form of preventative care.**
4. **The beneficial role Local Economic Anchors can play in tackling emerging public health challenges should be recognised by giving them a seat at the table on Health and Wellbeing Boards**. This would lead to further collaboration between all local stakeholders including the local health and social care sector, local authorities and business.
5. **Integrated Care Systems should be funded to employ health economists,** to evaluate public health initiatives within a place and their effect on local NHS demand.
6. **Roles should be created within Integrated Care Systems for marketing specialists,** to work with local authorities within the ICS area to develop links between the NHS, the local community and the commercial healthcare and fitness sectors.
7. **Constituent local authorities should be given a formalised role to act as conveners for Integrated Care Systems to actively engage with local educational institutions,** to ensure a holistic, joined-up health education system, sensitive to local context, is in place.
8. **CCG mergers should be halted and rolled back,** with the aim of achieving parity with local government to ensure the legitimacy of locally-delivered healthcare.
9. **Government, the NHS and local authorities must commit to greater collaborative working. Central to this, these partners must also sensitively and securely unlock greater potential from locally-derived patient data 'the jewel in the health service crown'.** This will mean funding to build robust systems for the effective storing, mining and analysis of larger databases including clinical and public health outcomes at appropriate sub-regional level. From this point forward, joint funding arrangements involving NHS England should be put in place, with the goal of analysing the success of health interventions across local public services.

10. **In line with existing reforms to public property assets, efforts should be made by managers of the NHS estate to co-locate different healthcare professionals from across the health service** – e.g. GPs, nurses, pharmacists – in modern working environments within the community that support best patient care.

11. **A joint nursing role that combines health and social care responsibilities should be created**. This would accelerate steps toward delivering integrated care, give nurses a practical understanding of what this means, and offer concrete career prospects. For example, by employing individuals on a rotational basis whereby they work part time in the community, and part time in the acute setting, one would develop a range of skill sets, which would allow people more scope and opportunity regarding their career prospects.

12. **A comprehensive immigration system that puts place-based needs first is essential post-Brexit. We propose a deal whereby visa quotas per sector are devolved to local government as they are best suited to know the needs for growth in their area.** Local authorities in partnership with local NHS trusts are in a better position to identify their and recruit for themselves. Even outside of healthcare, local authorities can identify key sectors where immigration is needed and can fill gaps whilst creating incentives for people to take opportunities to train and work in their areas.

13. **Efforts should be doubled to reverse the fall in numbers of nurses, GPs, and other health and social care professionals through a focus on increased homebased training**. A start should be reversing the abolition of bursaries for nursing students. More institutions and places to study should be made available, with clear incentives laid out for training in specialities where there are current shortages. This should involve having clearly laid out opportunities for an upward career trajectory to boost morale.

14. **Efforts should also be made to attract more young British people to work in social care, especially in areas which have experienced a brain drain and thus have a higher median age**. This involves a necessary boost of investment into the social care budget, which would allow for raising wages, and creating new opportunities and prospects for social workers.