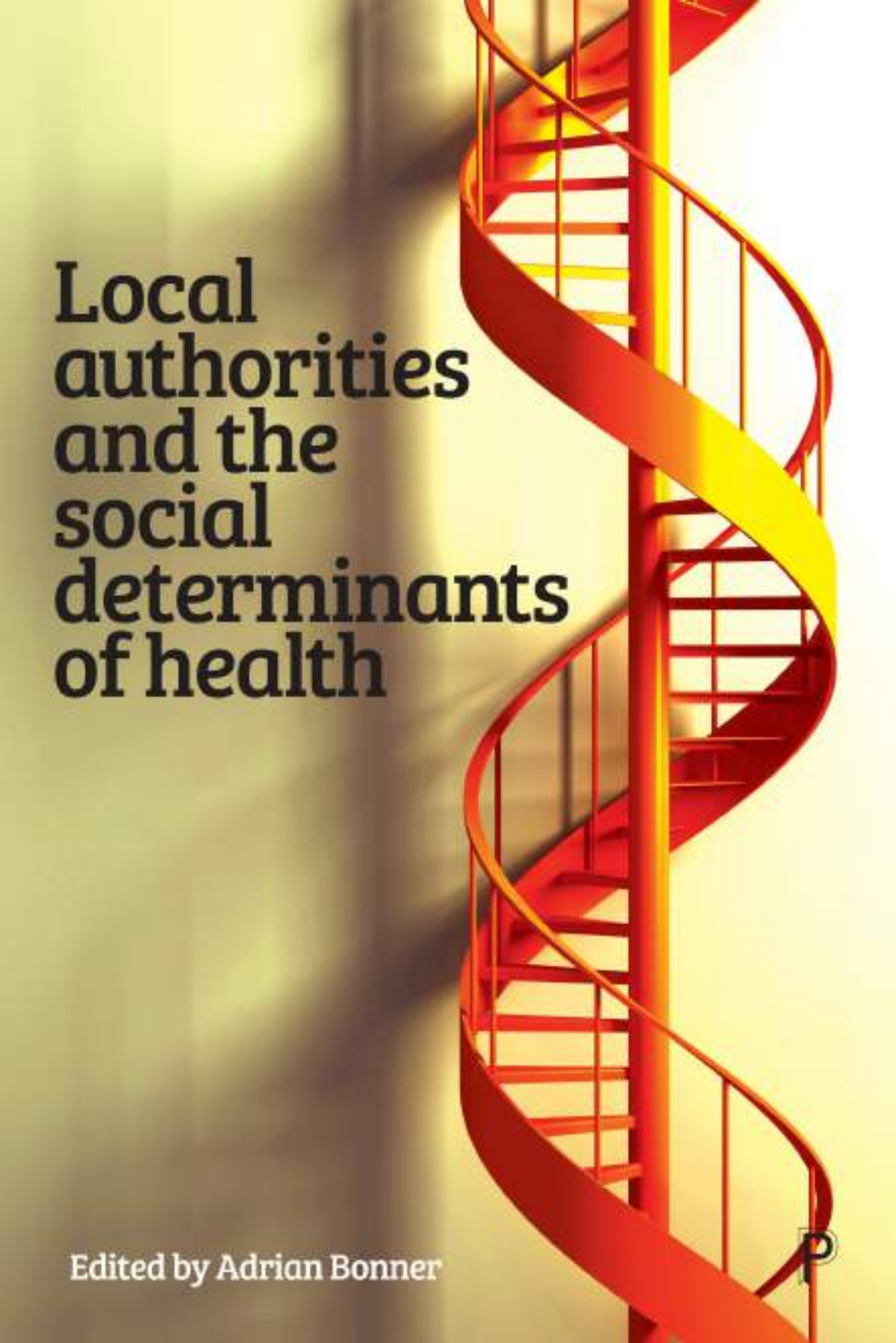
Local authorities and the social determinants of health



Edited by Adrian Bonner

LOCAL AUTHORITIES AND THE SOCIAL DETERMINANTS OF HEALTH

Edited by
Adrian Bonner

Foreword by Rhodri Williams QC

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To Gill, Adam, Kirsten, Gemma, Jake, Hope,
Thea, Cassian, Freya, Zachary

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Editor

Adrian Bonner currently focuses his research on the impact of economic austerity policies on health, social care and housing strategies, reflected in the publication *Social Determinants of Health: An Interdisciplinary Approach to Social Inequality and Wellbeing* (Policy Press, 2018). A key theme emerging from this current collaborative work is the recognition of the need for partnerships between the public, private and third sectors in addressing the range complex issues ('wicked issues') related to the social determinants of health. *Local Authorities and Social Determinants of Health*, the second book in the social determinants series, has provided a platform for the development of the Centre for Partnering (CfP), co-founded by Adrian and other contributors in this book, a network of universities working with the public, private and third sectors.

Adrian's early research was concerned with neurobiological aspects of alcohol, as reflected in publications and teaching activities in the 1990s at the Universities of Surrey and Kent. At this time, he became Chairman of the Congress of the European Society for Biomedical Research into Alcohol (Bonner, 2005). *Social Exclusion and the Way Out: An Individual and Community Response to Human Social Dysfunction* (Bonner, 2006) provided the basis for research into *The Seeds of Exclusion* (Bonner et al, 2008), a major report that continues to influence Salvation Army strategic planning. These activities were undertaken while he was a Reader in the Centre for Health Service Studies, University of Kent, and Director of the Addictive Behaviour Group, which facilitated the development of undergraduate and postgraduate teaching and research activities.

From 2010 to 2012, he was seconded from the University of Kent to become the Director of the Institute of Alcohol Studies. This involved participating in the UK government's Responsibility Deal and membership of the European Alcohol Health Forum, an advisory group supporting the work of the European Commission. These insights into UK and European policy development have influenced his current activities, which include interdisciplinary research into health inequalities and membership of HealthWatch and the Joint Mental Health and Wellbeing Clinical Commissioning Group in the

London Borough of Sutton. He is an honorary Professor in the Faculty of Social Sciences, University of Stirling.

Contributors

Isobel Anderson is Chair in Housing Studies and Research Director for the Faculty of Social Sciences at the University of Stirling, Scotland, where she has worked since 1994. She has research, teaching and supervision interests in housing policy and governance; inequality and social exclusion; homelessness; health and wellbeing; and international comparisons. She has held research grants from a range of funding agencies and published widely for scholarly, policy and practice audiences. Isobel was a founder of the European Network for Housing Research working group on Welfare Policy, Homelessness and Social Exclusion, which she jointly coordinated from 2003 to 2013; and in 2015 she joined the network's coordination team for the working group on Housing in Developing Countries. She is also a member of the Women's Homelessness in Europe Network, is on the International Advisory Committee of the *European Journal of Homelessness* and is a board member of Homeless Action Scotland.

Kate Arden is Director of Public Health, Wigan Council. Kate attended Manchester High School and read Medicine at Manchester University. She was awarded the Royal College of General Practitioners Professor Patrick Byrne Prize for General Practice. Kate has an MSc in Epidemiology and Health and Membership of the Faculty of Public Health. She was awarded Fellowship of the Faculty of Public Health 2006. Kate has an Honorary Professorship at Salford University, where she is a co-researcher on the National Institute for Health Research-funded evaluation of Greater Manchester's innovative Communities in Charge of Alcohol programme. Kate is also a Visiting Professor at Chester University. She is Lead Director of Public Health for the Greater Manchester Combined Authority for Health Protection and Emergency Planning & Response, in addition to her substantive post as Director of Public Health for Wigan, where she is also Chief Emergency Planning Officer and the council's Chief Commissioner for Leisure Services. She is currently lead Director of Public Health for the Greater Manchester Health and Social Care Partnership for alcohol and substance misuse harm reduction and health protection transformation, including the development of a multi-agency antimicrobial resistance programme for the conurbation and has led the Greater Manchester health protection sector-led improvement work

on which she was asked to attend and give evidence to the House of Commons Health Select Committee as part of their inquiry into public health functions in England, post-2013. Kate co-chairs the Greater Local Health Resilience Partnership and is a member of both the Greater Manchester Resilience Forum and the Greater Manchester High Rise Taskforce set up by Mayor Burnham in response to the Grenfell fire. Since March 2016, Kate has been a trustee of the Royal Society of Public Health, and she was one of the external experts consulted on the Scottish Government's national public health review.

Dave Ayre is the Property Networks Manager for the Chartered Institute of Public Finance and Accountancy (CIPFA) and advises on asset management, partnering and wider property issues throughout the United Kingdom (UK). He is a qualified public service manager with extensive experience in the development, procurement and implementation of innovative public/private partnerships. He has considerable local government experience and has also worked as a consultant to public and private sector organisations delivering public services. He has contributed at a national level to the development of successive government performance management regimes for planning, property and construction through the Planning Officers Society, the Local Government Construction Taskforce and Constructing Excellence, and written guidance on collaboration between public sector organisations. In his contribution, Dave draws on his own experience and sets it against the wider social and political trends governing the relationships between public and private sectors.

Nigel Ball is the Executive Director of the Government Outcomes Lab (GO Lab), which is based in Oxford University's Blavatnik School of Government. Nigel leads the work of engaging government commissioners and decision-makers with evidence about how to effectively commission services for populations with complex social needs. Prior to joining the GO Lab, Nigel was part of the founding team of West London Zone for Children and Young People, where he set up a Collective Impact Bond that leveraged multiple public and private sources of funding to be paid when a partnership of mainly local charities supported at-risk children to achieve better outcomes. Nigel's previous roles include Head of Innovation at Teach First, the leading education charity, and supporting social entrepreneurship in East Africa. He is a qualified teacher, having learnt his craft in a secondary school in Eccles, Manchester. He holds a first-class BA in English and Linguistics from the University of York.

Michael Bennett is a Co-Founder of the Centre for Partnering and the Director of Public Intelligence. Previously, he was a Director of the Society of Local Authority Chief Executives, where he held a number of senior policy roles.

Adam Bonner has an academic background in Human Resource Management at the University of Kent. He has worked professionally and voluntarily with regional and national youth organisations in the UK for 20 years. This work involved creating new community-funded and volunteering programmes. In 2007, he became regional and then national community development manager for the Shaftesbury Society, developing community initiatives for young people and focusing on those in deprived communities. Following the merger of the Shaftesbury Society with John Grooms to create the newly branded Livability 2007, he became Director for Community and Communications and then in 2013 became Executive Director of Public Engagement. In 2018, he became Director of the Youth United Foundation, an umbrella organisation working with 11 uniformed groups, including Scouts and Guides, to engage with young people on the margins of society. In 2019, he was the founder and director of a community interest company, Sutton Community Dance.

Harry Burns graduated in medicine from Glasgow University in 1974. He trained in surgery and became a consultant surgeon in the University Department of Surgery at the Royal Infirmary in Glasgow. Working with patients in the east end of Glasgow gave him an insight into the complex interrelationships between social and economic status and illness. He completed an MA in Public Health in 1990 and shortly afterwards was appointed Medical Director of The Royal Infirmary. In 1994, he became Director of Public Health for Greater Glasgow Health Board and he continued research into the social determinants of health. In 2005, he became Chief Medical Officer for Scotland. His responsibilities included public health policy, health protection and, for a time, sport. He was knighted in 2011, and in April 2014 became Professor of Global Public Health at Strathclyde University, where he continues to research how societies create wellness.

Tony Chasteauneuf has an MA in Voluntary Administration from London South Bank University and an Honours degree from Durham University. He has been involved in the development and strategic management of homelessness services, community development projects, community services, not-for-profit management and the

faith sector in the UK and Australia. Currently, he is the Regional Specialist for Community Services (Yorkshire and the North East of England), The Salvation Army.

Keith Clements is a researcher and policy expert focussing on children's health and social care services in England. Over the course of his career he has led and contributed to the development of a number of high-impact reports exploring the effects of inequalities on children and young people. This includes leading research on behalf of the All Party Parliamentary Group for Children on children's social care and on behalf of the National Children's Bureau on the impact of health inequalities in the early years. His work has also focussed on joint working between public sector and voluntary organisations to meet the needs of vulnerable children. Keith is currently Senior Researcher at the National Children's Bureau. He has previously worked for the Council for Disabled Children and Ambitious About Autism.

Anna Coleman is Senior Research Fellow in the Health Organisation, Policy and Economics research group at the University of Manchester. She is a skilled policy researcher, having extensive experience over many years researching into and publishing on health and care policy, partnership working and commissioning. She investigated the implementation of health scrutiny for her PhD (2003–6) and has most recently been looking at new models of care, integration and place-based planning in health and care – Vanguards, integrated care systems and Greater Manchester health and social care devolution. Previously, Anna worked in policy and research within local government and is recognised beyond the university as an expert in the increasingly important intersection between health policy and local government, having been invited to speak at an international conference on municipalities and health, provided written evidence to Health Select Committees and given personal advice to a member of the House of Lords and to external organisations.

Mark Cook is partner at Anthony Collins Solicitors, having advised on procurement and public–private partnerships for 30 years. He is the lawyer who has most contributed to the inclusion of community benefits at the core of public contracts in the UK. He contributed to the drafting of the Public Services (Social Value) Act 2012 and the content of the Procurement Reform (Scotland) Act 2014. He also contributed to the Can Do Toolkits in Wales. He is company

secretary to catalytic do-tank Collaborate, and he is deeply committed to creating alternatives to the commissioner– contractor dynamic.

Penny Cook is Professor of Public Health and leads a research group, Equity, Health and Wellbeing at the University of Salford. She has attracted £4 million in research funding in her career to date, investigating health impacts of alcohol and tobacco as well as research into sedentary behaviour, physical activity and the health and wellbeing benefits of green space. Current projects include investigating an asset-based community development intervention, whereby members of a community can support each other with alcohol advice (funded by the National Institute for Health Research). Penny also researches on foetal alcohol spectrum disorders (FASD). She is currently developing a parenting intervention for families affected by FASD (funded by the Medical Research Council) and is leading the first UK study into their prevalence. Penny is a co-investigator on the National Environment Research Council-funded Green Infrastructure and the Health and Wellbeing Influences on an Ageing Population project. She also teaches on the MSc in Public Health.

Keith Cunliffe is the Deputy Leader of Wigan Council and has had the Portfolio for Health and Adult Social Care since 2008. He is Joint Chair of the Wigan Health and Wellbeing Board. Keith is a member peer at the Local Government Association, providing peer review, mentoring and workshops to a number of local authorities. He is also the national Vice-Chair of the Industrial Communities Alliance.

Jeanelle de Gruchy is President of the Association of Directors of Public Health and Director of Population Health, Tameside Metropolitan Borough Council. Formerly, Jeanelle was Director for Public Health for Haringey, and public health lead on health inequalities and public mental health, becoming director for Haringey Clinical Commissioning Group (CCG) in 2010.

Paul Dennett was elected Salford City Mayor in May 2016. Before then, Paul served as a local councillor in the Langworthy ward of the city, and held the workforce and equalities portfolio on the city council's cabinet. Being born in Warrington into a working-class family had a significant impact on Paul's politics and life-long appreciation for the public sector, health care, education and the emergency services. He worked in customer services at a BT call centre and, after completing his degree, lectured in Business at

Manchester Metropolitan Business School. Paul is currently also the Greater Manchester Combined Authority portfolio lead for housing, planning and homelessness.

Ruth Dombey has been the Leader of the London Borough of Sutton and has chaired its Health and Wellbeing Board since 2012. She is a trained facilitator for the Local Government Association, specialising in courses for councillors and general practitioners who chair health and wellbeing boards. She is also one of the Vice-Chairs of London Councils and Deputy Leader of the Liberal Democrat group on the Local Government Association.

Catherine Farrell is based in Cardiff Business School and her research interests are in the areas of public management and governance. She has published widely on school governance and the role of public boards in public service improvement. She is currently researching different models of public board governance including the stakeholder, elected, appointed and skills-based approaches in a range of different services, including the fire and rescue service. She has undertaken an evidence review of aspects of the Well-Being of Future Generations Act and public services. Her work has been published in journals including *Public Administration*, *Policy and Politics*, *Local Government Studies* and *Human Relations*.

Chris Fox is Professor of Evaluation and Policy Analysis at Manchester Metropolitan University where he is also Director of the Policy Evaluation and Research Unit and co-lead of Metropolis – an academic-led think tank. Chris is involved in a wide range of evaluation and research projects in a number of policy areas, including criminal justice, social investment and welfare reform. He is particularly interested in the role of co-design in public sector reform.

Max French is a lecturer in Systems Leadership at Newcastle Business School, Northumbria University, and a Visiting Fellow at the Open Lab, Newcastle University. His research focusses on two areas of practice. Firstly, he studies the implications of complexity and complexity-informed practice for public administration and non-profit management, centring on the development of new methods, models and approaches. Secondly, he researches the use of action-oriented approaches to social research as a means to improve research relevance.

Gillian Gibson is Director of Public Health, Sunderland. She has lived in Sunderland for most of her life and worked in the National Health Service (NHS) from 1984 until 2013, when responsibility for public health transferred to local government. She is a registered public health specialist and has been a consultant in public health in Sunderland since 2011, taking responsibility for the integration of public health services. She became Acting Director of Public Health in April 2015.

Tim Gilling is a Director at the Centre for Public Scrutiny (CfPS), the leading UK governance and scrutiny organisation. He delivers national programmes in England for major clients such as the Department of Health and Social Care, NHS England, Public Health England and the Care Quality Commission. Tim also has experience of local government and health issues in Scotland and Wales. He works with councils and health bodies around integration and service reconfiguration and strengthening relationships between health bodies and council scrutiny. He recently published a guide for council scrutiny committees to ask about social value policy and outcomes. As well as his public policy, local government and healthcare experience, Tim also works with the private sector, currently in construction and energy. He also brings practical experience of governance in the education and charitable sectors. He is a member of the UK Administrative Justice Council and a Fellow of the Royal Society of Arts.

Peter Hain has led a colourful life. The child of South African parents who were jailed, banned and forced into exile during the freedom struggle, in 1969 and 1970 he led anti-apartheid campaigns to stop all-white South African sports tours. MP for Neath from 1991 to 2015 and a Privy Councillor, Peter served in the UK Government for 12 years, seven of these in the Cabinet. He negotiated the 2007 settlement to end the conflict in Northern Ireland and was a Foreign Minister with successive responsibilities for Africa, the Middle East and Europe. He has chaired the United Nations Security Council and negotiated international treaties. He was also Secretary of State for Work and Pensions, Secretary of State for Wales, Leader of the House of Commons and Energy Minister. His concise and readable biography *Mandela His Essential Life* was published in 2018, his memoirs *Outside In* in 2012 and his co-authored *Pitch Battles: Protest, Prejudice and Play* in May 2020. He has written or edited 21 books, and has also appeared regularly on television and radio and written for most UK newspapers.

Melissa Hawkins is currently a researcher at Newcastle University Business School, and is conducting action research into developing complexity-informed practice in public and third-sector organisations. Research interests have been influenced by time spent as a classroom teacher, and they are focused upon how complexity theory can be used to critically analyse current performance management practices, and how action research can be utilised as a methodology for innovating in complex conditions.

David J. Hunter is Professor of Health Policy and Management, Institute of Health and Society, Newcastle University. David graduated in political science from Edinburgh University. His academic career spans over 40 years, during which he has researched complex health systems, with a focus on how health policy is formed and implemented. Between 1999 and July 2017, David was Director of the Centre for Public Policy and Health at Durham University. The centre was designated a World Health Organization Collaborating Centre in Complex Health Systems Research, Knowledge and Action in 2014. In August 2017, he transferred to the Institute of Health & Society, Newcastle University, and became an Emeritus Professor in August 2018. Recent former positions include being a non-executive director of the National Institute of Health and Care Excellence (2008–16); an Appointed Governor of South Tees Hospitals NHS Foundation Trust (2009–17); and a special advisor to the UK Parliamentary Health Committee. He is an honorary member of the UK Faculty of Public Health and Fellow of the Royal College of Physicians (Edinburgh).

Edward Kunonga is currently a consultant in public health working for Tees, Esk and Wear Valleys Mental Health NHS Foundation Trust and County Durham and Darlington Acute NHS Foundation Trust. Edward spent nine years as the Director of Public Health and Public Protection for Middlesbrough Council, and during the last three years of that tenure he was the joint director of public health across Middlesbrough and Redcar and Cleveland Borough Councils (the first joint public health service in the North-East). As part of this arrangement, Edward was instrumental in the development of the joint health and wellbeing board across these two local authorities, chief officer for emergency preparedness and response for the council and took a regional lead role for public mental health. Edward has an MSc in Epidemiology from the London School of Hygiene and Tropical Medicine, an MBA from Leicester University and a Diploma in Epidemiology and Public Health from the Faculty of Public Health

of the Royal College of Physicians UK. He also has a diploma in Lifestyle Medicine and is a certified lifestyle medicine practitioner. He was awarded Fellowship of the Faculty of Public Health 2011. Edward has Honorary Professorship at Teesside University and contributes to a wide range of teaching and research activities.

Jennifer Law is an expert on local government, particularly in relation to public service improvement, performance measurement and strategy. She has published widely in these areas and has also provided advice and consultancy to organisations including Public Health Wales, Welsh Government, CIPFA, as well as a number of local authorities and other public bodies. Her most recent work has been for Public Health Wales and has focused on the enablers and barriers of the Well-being of Future Generations Act and on the equality implications of the Act.

Toby Lowe is a senior lecturer in Newcastle Business School at Northumbria University, working on partnerships to achieve social change. This work includes research and collaborative publications in the funding of complex ecologies. Previously, he was Chief Executive of Helix Arts, and he works with Collaborate to support funders and help senior commissioners respond to complexity.

Jim McManus is Vice-President, Association of Directors of Public Health and Director of Public Health, Hertfordshire County Council, is a chartered Psychologist, Chartered Scientist and public health specialist.

Gayle Munro is Head of Research and Evidence at the National Children's Bureau, London. Gayle's doctoral work (Geography, University College London) explored the transnational experiences of migrants from the former Yugoslavia to Britain. Gayle has worked in the voluntary sector for more than 20 years and has held research and teaching positions at The Salvation Army (London), the Organisation for Security and Cooperation in Europe (Bosnia & Herzegovina), the European Centre for Minority Issues (Germany), Lemos & Crane (London) and Sichuan University (China).

Alison Navarro has 30 years' experience of working with local communities, the voluntary and community sector, partnership bodies and public sector agencies. Her first role was a Community Development Officer within the City Challenge Regeneration

Programmes in Liverpool and then later as a Programme Manager for an inner city Single Regeneration Budget Programme in Liverpool. As a Partnership Manager, Alison supported the development of local strategic partnerships and community strategies. In the early 2000s, she set up her own training and consultancy firm where she worked with a range of people and organisations, all of her work being linked to her passions for social justice. In later years, Alison has been involved in the Infrastructure movement, and she spent some time at Community Links Bromley before becoming the chief executive officer at Community Action Sutton in 2016.

Chris O'Leary is a public policy specialist and Deputy Director of the Policy Evaluation and Research Unit at Manchester Metropolitan University. He has written and commented on issues around commissioning and procurement, particularly on the barriers faced by local charities and small businesses. His empirical research focuses on social innovation, particularly where different parts of social provision interact. Much of his published research is around housing/homelessness and its interaction with health and social care, and the criminal justice system

Dean Pallant is Secretary for Communications (The Salvation Army UK and Republic of Ireland), previously Director of The Salvation Army's International Social Justice Commission-based in New York City. His doctoral studies at King's College London resulted in the publication of his first book, *Keeping Faith in Faith-Based Organisations*, in 2012. Dean was a founding member and director of the Joint Learning Initiative on Faith and Local Communities.

Catherine Parker is a consultant in public health and has lived and worked in the North-East all her life. Her career in health started in 2003 as part of the NHS graduate management programme, where a passion for public health was quickly established. Catherine has held a variety of roles in health and public health commissioning and strategic management working at local and regional to national level on health improvement and inequalities. She is a registered public health specialist since and Consultant since 2018.

Glenda Roberts currently works for Avante Care and Support as Head of Care Homes – Kent, assisting with reviewing and directing all aspects of the organisation's work in a portfolio of care homes. Prior to her current position, she was Deputy Director of Older People's

Service for The Salvation Army. She was Master's educated at the University of Stirling, with a specific interest in dementia studies, and has been a qualified Registered Adult Nurse since 2002, with 18 years of experience supporting young adults with complex needs and older adults in health and social care settings in both the third sector and private sector.

Jacquie Russell is the Assistant Director Policy and Performance at Salford City Council, a post she has held since 2012. In this role, Jacquie has worked with colleagues across the city council and Salford CCG to successfully create integrated funding, governance and joint working arrangements for health and care in the city, Jacquie has also led work to bring together the city's Tackling Poverty and Inequality Strategy. Before working in Salford, Jacquie held posts in Manchester City Council, Government Office for the North West and the Home Office. Before then, she held various policy positions in the Australian civil service.

Jolanta Shields has recently submitted her PhD in the School of Social Sciences at the University of Manchester. Her research, funded by the Economic and Social Research Council (ESRC) and a Manchester President's Doctoral Scholar Award, concerns the role of new providers of health care services, Community Interest Companies, in the NHS. During her PhD, the ESRC funded an internship at CfPS where Jolanta published *Governance of Sustainability and Transformation Plans*. She was a researcher for the report 'A Shared Responsibility: Tackling Inequalities in Health Across Greater Manchester', commissioned by the Oglesby Trust. Prior to academia, Jolanta had a successful career in local government working for the Third Sector and Policy Team at Manchester City Council.

Richard Simmons is a senior lecturer in Public and Social Policy and Co-Director of the Mutuality Research Programme at the University of Stirling. Over the last decade or so, he has led an extensive programme of research on voice and cooperation in public policy. This includes four studies funded by the ESRC/Arts and Humanities Research Council, a Single Regeneration Budget-funded study and work for the NHS, Scottish Executive, National Consumer Council, Carnegie Trust, the Organisation for Economic Co-operation and Development, World Bank, Co-operatives UK, Nesta and the Care Inspectorate. He is currently working on a European Union (EU) Horizon 2020 project, working with local municipal governments

and schools to improve the quality of primary school meals through better procurement. He writes widely on these issues for academic, policy and practitioner audiences. His book, *The Consumer in Public Services* is published by the Policy Press. As well as a series of journal articles in high-quality international journals such as *Social Policy and Administration*, *Policy and Politics*, *Annals of Public and Co-operative Economics* and *Public Policy and Administration*, Richard has written a number of policy-oriented publications and professional journal articles for a practitioner audience. His research interests are broadly in the field of user voice, the governance, delivery and innovation of public services and the role of mutuality and cooperation in public policy. The Mutuality Research Programme has acquired an international reputation as a centre of excellence for research, knowledge exchange and consultancy on these issues.

Richard Smith has enjoyed various senior management positions in both public and private sectors. He has developed a variety of commercial skills within the defence sector and legal skills, qualifying as a barrister in 1978. In the second phase of his career, he founded Public Sector Plc, a private sector organisation utilising a new and innovative legal framework based on a cultural relationship between partners forming in advance of formal legal commitments. His work has been based on the principles of 'insourcing', which was the notion of the market strengthening the public sector not replacing it. His work in the public/private partnering field formed part of the Public Sector Plc Government Pilot Partnership Network established to consider Best Value and its introduction. This opportunity came about at the same time as he presented evidence to a House of Commons Select Committee. Currently he is in discussions with a number of universities to establish the CfP to undertake research programmes in this partnering field and to consider the positive impact it can have on delivering socio-economic benefits to local communities, particularly in the field of health. This work builds upon his experience of setting up the Local Government Council Consortium Group, which was a group of 22 councils that delivered a 'Commission' Report containing 11 recommendations on unlocking additional value from local authority property estates. Richard is an Honorary Professor at the University of Stirling and Chairman of CfP.

Steve Thomas has over 30 years of experience working within local government. In 2004, he became Chief Executive of the Welsh Local Government Association, the representative body of the 22 Welsh

councils. Here he also co-developed with Public Health Wales the Cymru Well Wales partnerships aimed at tackling key determinants of ill health. Having retired from this role, Steve now lectures in the Faculty of Business and Society at the University of South Wales within the fields of strategy, leadership and organisational change.

Tony Thornton is Regional Manager, Homelessness Services Unit (HSU) North-East Region, The Salvation Army. Educated and living in Darlington, County Durham, he has worked for The Salvation Army since 1993: he was a centre manager for over eight years, working with vulnerable homeless adults and managing a staff team of 21. He was awarded an MBE in 2008 for services to Homelessness. He then joined The Salvation Army Housing Association (SAHA), which, working as an Independent Quality Inspectorate, inspected all SAHA and Salvation Army services. He remained with SAHA for three years before joining The Salvation Army again as the Assistant Regional Manager HSU North East, and he is now the Regional Manager – having had in total five years' experience of regional management, at the same time gaining a Master of Science in Housing Studies in 2017 from Stirling University.

Lord Graham Tope CBE was a councillor in the London Borough of Sutton for 40 years until 2014 and leader of that council for 13 years. He was a member of the London Assembly from 2000 to 2008 and leader of the five-member Liberal Democrat Group for six of those years. He was a UK delegate to the EU Committee of the Regions (the voice of regional and local government in the EU decision-making process) for 20 years, leading its European Liberal Group for part of that time. Graham was Liberal MP for Sutton & Cheam from 1972 to 1974 and was made a life peer in 1994. He has been Liberal Democrat Education spokesperson in the Lords and was co-chair of the Lib Dem Communities & Local Government Parliamentary Committee throughout the five years of the Coalition government. He is Co-President of London Councils.

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Foreword

Rhodri Williams QC

The General Election on 12 December 2019 resulted in a Conservative government that, with a majority of 80, was mandated to 'Get Brexit Done'. The socio-economic background to the Referendum result, in 2016, to leave the European Union (EU), has its origins in the 19th century. The industrial revolution contributed to Britain becoming a wealthy colonial power. The dark side to this economic growth included slavery, exploitation of working people and poor health for those who stoked the fires of the 'dark satanic mills'. The extremes of wealth and social deprivation had political consequences, resulting in the emergence of trade unions and origins of the welfare state. The political drivers resulting in the United Kingdom (UK) leaving the EU in 2020 include a significant response from people living in traditional labour-supporting communities, particularly in South Wales and the northern parts of England. People voting to leave the EU have experienced the outcomes of authority budgets undermining welfare support, pressures on the National Health Service (NHS) and social care and concerns about threats, real or imagined, to employment owing to the free movement of people within the EU. Feelings of being left out of the economic growth of the UK, the increasing gaps between socially deprived and those better off, and the lack of personal actualisation is noted by Burns in Part I, Chapter 1, as a key determinant of the 'deaths of despair' and decreasing life expectancy.

The growing concern about the links between social conditions and the state of public health led to the emergence of modern local government in the UK. In recent years, a greater understanding that wellbeing of people is an important determinant of the economic prosperity is demonstrated by the 'wellbeing' budget being introduced by the New Zealand Government, reported in *The Guardian*, 30 May 2019.

In 1945, Clement Attlee's Labour government was elected at a time of severe post-war austerity. It marked the start of a new social-democratic consensus that was to develop over 30 years under successive governments. The election of Margaret Thatcher's Conservative government in 1979 up-ended this post-war consensus. The free market think tanks of the Adam Smith Institute, the Institute

for Economic Affairs and the Centre for Policy Studies influenced the government to embark on a programme of wholesale privatisation. The Local Government Acts of 1988 and 1992 introduced and extended compulsory competitive tendering (CCT). Services such as waste collection, construction, grounds maintenance and catering were some of the first to be affected. This was later to be extended to white collar architectural and civil engineering design services towards the end of the John Major Conservative government. Although an enthusiastic proponent of CCT, the Major government was keen to portray a less ideological approach to public services than its predecessor.

The relationship of public and private sectors in the UK and the commissioning, procurement and development of public private partnerships has been driven by the prevailing political and economic environment. In 1992, the Major government introduced the Private Finance Initiative (PFI) and branded it as a new form of public–private partnership. The New Labour government of Tony Blair embarked on an ambitious programme of new hospitals, schools and highways infrastructure funded by PFI. While the Major government signed 21 PFI deals, by the end of Blair's term as prime minister in 2007, 850 had been signed.

The health and wellbeing of people is linked with the economic status of the country. This book presents the social determinants of health rainbow model (Dahlgren and Whitehead, 1991) perspective on local authorities and their changing approaches to procurement and commissioning. While this model of health and wellbeing, promoted by the World Health Organization, has influenced the development of health systems globally, only recently has local government begun to adopt this approach in integrated planning. Centralisation, delegation, devolution and privatisation have been adopted by successive governments in addressing growing demands across the health and social care system. Chapters from a number of local authorities (LAs) in Part II of this book indicate a cultural change in recognition that social determinants and 'health in place' should underpin responses to joint needs assessments. The chapters in Part II provide an insight into the impact of austerity on local authority budgets and individual LAs' responses to protect the wellbeing of their communities. This response is influenced by geo-sociopolitical circumstances, such as local opportunities for employment (particularly in the North-East, Chapter 7), the extent of devolution (for example, so-called 'devo max' in the North-West, Chapters 5, 8) and the culture of commissioning.

The Localism Act and the Care Act, conceived by the Coalition government (2010–15) have brought a major cultural shift in thinking

and planning. These were well-intentioned legislative changes but LAs, with decreasing funding from Central government, have greater responsibilities for their communities undermined by austerity budgeting. In searching for innovative approaches to dealing with the rise in the diseases of modern society, such as obesity and Type 2 diabetes, this wider view of health and wellbeing has promoted prevention and the embedding of public health strategies in all policies. LAs are seen to be uniquely positioned to facilitate this transformation, as they are close to local communities and have an understanding and responsibility for issues such as environment.

Observations that life expectancy in the current century is stalling and health inequalities are rising, are concerning and have political implications with the gap in life expectancy between the richest and poorest areas of England and Wales widening over the past decade. Harry Burns, in Chapter 1, suggests that public policies fail as a result of attempts in the 1980s to make public services 'more business like'. New Public Management approaches, adopted by the NHS, have focused on customer service, financial control, value for money and increasing efficiency. 'Senior managers drive change by setting targets and indicators and performance monitoring. The wellbeing of the community, being difficult to conceptualise, rarely features in strategic plans or managers' objectives' (Burns, Chapter 1).

In Part III, the changing responses of LAs are reviewed. Public services are commissioned and delivered, often on the basis of a hard-lined demarcation between the responsibilities of council and contractor, when in fact if wellbeing is to be truly embraced, as suggested by Mark Cook, introducing Part III, a much more nuanced dynamic has to exist. This dynamic needs to take account of culture and competence on all sides: 'The connection between Best Value and wellbeing is one that is not well understood in central and local government.' The Wigan Deal (Part II, Chapter 8) is an example of a consultative approach in which cultural changes in public attitude and behaviour complement financial gains and cost savings in the council budget. As with the examples from other local authorities, place-based policies and working with local communities appear to provide a socio economic and political context to developing and supporting healthy communities.

CCT provided an opportunity to take over and run public services, but culture and competence would often be inappropriate to achieve outcomes necessary to address the needs. The inadequacy of the market came to be fully recognised with the externalisation process introduced in 1994 to 1995. It has become very apparent that if

future partnering is to be effective then there must be more emphasis on social, economic and community wellbeing issues being more effectively combined with the commercial and profit motive.

To do this, there must be more time to have joint dialogue within a flexible legal framework. If there can be more use of benchmarking for comparison of proposals and fewer automatic assumptions that tendering will always deliver best results, then this could be advantageous.

Richard Smith, a barrister by training, has considerable experience working within the public and private sectors in the local government, demonstrates in Chapter 10 that to overcome the different cultures and environments, time is required to jointly design project opportunities. This need not preclude competition and, if organised properly, enhances the outcomes financially and qualitatively for both partners.

EU law, particularly the EU treaty and the Procurement Directive 2014/24/EU, currently underpins the broad terms under which public procurement and competitive tendering operate in the UK; see Chapter 9. The rules have been transposed into national law as the Public Contracts Regulations 2015 by the UK's governments, establishing how public authorities, including health and social care commissioners, purchase goods, works and services.

Existing domestic legislation, such as the Health and Social Care Act 2012 and the NHS (Procurement, Patient Choice and Competition) Regulations 2013 in England, currently enshrines effectively the same rules as EU law. These laws, for example, prohibit NHS England or clinical commissioning groups (CCGs) from favouring a single provider and gave powers to the regulator Monitor, and its successor NHS Improvement, to enforce competition rules on NHS trusts.

The collapse of giant outsourcer Carillion in January 2018 was one of the highest-profile failures of the traditional outsourcing model. Carillion was a major strategic supplier to the UK public sector, its work ranging from building roads and hospitals to providing school meals and defence accommodation. It collapsed in January 2018 with some 420 public sector contracts. The Local Government Association estimated that 30 councils and 220 schools were directly affected. It had around 43,000 employees, including 19,000 in the UK. Many more people were employed in its extensive supply chains. Thousands of people lost their jobs. Carillion left a pension liability of around £2.6 billion.

The complex nature of public service requires public servants to be properly equipped with new, 'complexity-informed tools', as described by Toby Lowe, Max French and Melissa Hawkins in

Part III, Chapter 13. The task of creating positive social outcomes (such as improved wellbeing, increased employment or reduced crime) in complex environments as seen, in this chapter through the lens of public sector performance measurement and management (PSPMM), and how this has evolved towards increased complexity by moving from an output (activity) to an outcome (results) focus. Outcome commissioning is being used by an increasing number of local authorities, as noted in Part II, Chapter 6.

The original local government aims, as a first-line defence thrown up by the community against poverty, sickness, ignorance, isolation, mental derangement and social maladjustment, are severely challenged by severe cutbacks, which are causing them to target reductions in discretionary services in order to provide relative protection for statutory and more acute services. Improvements in public health during recent years resulted from heavy investment in alleviating adverse social conditions for children. The last ten years have seen a rapid withdrawal from this and other community assets, such as funding for youth clubs by local authorities: see Part IV, Chapters 15 and 16.

Michael Bennett, in Part V, Chapter 18, writes that although sustainability is cast as fulfilling legal obligations, rather than creating outcomes acceptable or desirable to society, there is ongoing rationing, with scarce resources being focused on a narrower group of people with highest care needs at the expense of prevention and wider social benefits. This is counter-intuitive to the social model of health, where there is an 'interconnectedness and interdependence of socio-economic, cultural, environmental, living and working conditions, social and community networks, and lifestyle choices that contribute to a person's health and well-being' (Bonner, 2018: xxi).

If we think about the future of partnering and overcoming the considerable culture differences that exist between public, private and voluntary sectors, then we must address the need to forge stronger relationships before entering into contractual commitment. A procurement regime that does not provide sufficient opportunity to build trust and transparency between potential partners at the outset risks a stiff inflexible relationship driven by contractual specification and tendering assumptions obtained during an expensive exercise in bidding for contracts.

The future opportunity that a post-Brexit environment offers is a chance to rewrite rules and regulations, not superimpose more changes and amendments on the existing regime. Let us put relationships first and contracts second!

Note

Rhodri Williams QC is a barrister specialising in EU law, local government law, public and administrative law. He deals with cases involving local and regional government, including advising the Welsh Government and other government departments and local authorities. He has represented the UK Government on several occasions before the Court of Justice of the EU in Luxembourg.

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Summary

This book addresses the key issues facing local authorities as they provide services and support their local populations.

Although the municipal corporations in the 19th century had responsibility for the community, populations were stratified, with those in the lower levels not well supported. The generation of wealth and the influence of socialist and liberal policies in the 20th century led to a cultural change in which respect and help for individuals was addressed by the setting up of the welfare state and the National Health Service.

With continued cultural and political change, expectations of support for the individual from the state have risen. We are now faced with the question as to who is responsible for the health and wellbeing of individuals and their communities. The simple answer could lie in the appropriate and fair allocation of resources by the locally elected members of councils that commission services. However, our changing understanding of the social determinants of health, regional differences in wealth and opportunities, and the defence of human rights should promote a fundamental rethinking of local approaches to health and wellbeing.

This book explores the challenges and responses of local authorities to the changing sociopolitical landscape by means of five sections addressing: Health, social care and community wellbeing; The role of local authorities in promoting health and wellbeing in the community; Local authority commissioning; The third sector; and Socio-economic political perspectives.

This interdisciplinary approach is being captured by a number of universities in discussion, collaborating in this publication, to promote relationship-building and the establishment of a Centre for Partnering (CfP); see Part IV, Chapter 10. This is a new initiative that is considering partnership and the future delivery of public services. Among the aims of the CfP are consideration of the various issues raised in this book, particularly as they relate to place-based services, and how collaborative economies could assist in the establishment of future sustainable economic models. This book raises 'wicked issues' within the context of the social determinants of health. The aim of the CfP, through universities working together, and collaborating with local authorities and the third sector, will be to consider how best to translate the issues and experiences encountered by the authors into positive and practical outcomes.

Introduction: Key sociopolitical changes affecting the health and wellbeing of people

Adrian Bonner

Following on from *Social Determinants of Health: An Interdisciplinary Perspective on Social Inequality and Wellbeing* (Bonner, 2018b), this volume provides a unique insight into the relationship between health and housing, regional disparities and responses across England, Wales and Scotland in the provision of health and social care and local authority commissioning. While references to the health care system will be found in the book, its primary focus is on health as defined in the Constitution of the World Health Organization (WHO), which was adopted by the WHO in 1946 and has not been amended since 1948: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity' (Anon, 1946).

The cultural changes leading to the development of the welfare state and contemporary system transformations are reviewed using examples of innovative approaches which involve shared responsibilities between statutory, third sector, community organisations and the private sector.

Cameron's Big Society (Anon, 2015a) was launched two weeks after the formation of the Coalition government following the general election of 6 May 2010. The key aims of the policy were, to increase 'community empowerment' by decentralisation with more power devolved to local councils and neighbourhoods; to promote 'social action' by encouraging people to play a more active role in communities; and 'opening up public services' by enabling charities, cooperatives social enterprises, and also private companies to compete in the delivery of public services.

> Because we believe that a stronger society will solve our problems more effectively than big government has or ever will, we want the state to as act an instrument for helping to create a strong society … Our alternative to big government is the Big Society. (Cameron, 2009)

Cameron's Big Society can be traced back to Tony Blair's Third Way, which aimed to unlock potential within society, promoting social

capital to provide added value to the state and financial markets. Gordon Brown promised to 'empower communities and citizens and ensure that power is more fairly distributed across the whole of society'. A number of strategies have been launched and relaunched by the main political parties. However, a three-year review, by Civil Exchange (Anon, 2015b) concluded that 'social action' had not increased, communities have not been empowered and the Big Society has not reached those most in need. In 2019, volunteering within the third sector is thriving, as noted in Part IV; but it was a fallacy of the Third Way and the Big Society that gaps in resources due to downsizing of the welfare state could be filled by volunteers. Austerity policies, resulting from the global economic recession of 2008, and some would say political ideology, have resulted in family budgets being significantly squeezed, and social mobility has decreased. Welfare reform and shortages in the housing market, financial uncertainty due to the protracted negotiations relating to the United Kingdom (UK) leaving the European Union (EU), all provide challenges to local authorities, whose elected members are faced with increasing problems owing to diminishing funds from central government. Many local councils have cut and reduced services, impacting on health and wellbeing; this has the paradoxical effect of increasing acute health costs in the long term. Community services such as bus services, clubs for young people and safety nets such as children's centres impact on health directly, as mobility, social interaction and family support are affected. Indirect effects result from the loss of self-esteem and other psychological factors, as highlighted in the Marmot Review (Marmot, 2010).

Recent policy developments have to a large extent been based on amplifying social capital (human relationships and networks), in addition to human capital (skills and knowledge of individuals, and workforce shaping). However, a pivotal resource in developing communities is wealth and its distribution. The control of financial resources is central to past and current support for people and their communities. There have been major changes in the control of financial capital from the 19th to the 21st centuries.

Municipalisation and social reform

The Municipal Corporations Act (1835) led to the establishment of elected town councils. Welfare provision was at the heart of these councils, with 'municipal socialism' inspiring work for the common good, significantly influenced by social reformers including Joseph Rowntree (1836–1925), Lord Shaftesbury (1811–51), Charles Booth

(1840–1916), William Booth (1829–1912) and others (Bonner, 2006). The actions of these social reformers and philanthropists laid the foundations of the third sector; see Part IV. The Beacon Project, from the Centre for Philanthropy at the University of Kent (Breeze, 2019), provides helpful insights into the historical and contemporary importance of philanthropy, and was based around ongoing work into third sector activity.

Local council activity led to the building of houses and hospitals, the creation of parks, museums, libraries and swimming pools, and welfare provision. Municipalisation included the purchase of gas, electricity, water and tramway systems, as it seemed logical that a local authority should ensure the availability of essential services for its residents. The benefits of affordable prices for these services, their safety and the reinvesting of income into further improvements was evident: 'by 1901, one reformer looked forward to the time when joy will be considered as much a necessity in a city as anything else. In that time citizens, well convinced that all the prime necessities of life must be municipalised' (Anon, 2015b). In 1930, a Member of Parliament observed that 'a young person today lives in a municipal house, and he washes himself in municipal water. He rides a municipal tram or omnibus, and I have no doubt that before long he will be riding in a municipal aeroplane. He walks on a municipal road; he is educated in a municipal school. He reads in a municipal library and he has his sport on a municipal recreation ground. When he is ill he is doctored by a municipal hospital and when he dies he is buried in a municipal cemetery…' (Anon, 2015b). The management of water supplies, sewage systems, air quality, and the physical and social environment are key contributors to public health, as reviewed in Chapter 2.

The origins of local authorities

In the mid- to late 20th century, municipalisation gave way to centralised government, which subverted the autonomy of local authorities. Council-owned water, electricity, water assets were nationalised in 1945. Municipal hospitals were nationalised within the National Health Service (NHS) and gradually local authority powers were reduced, in the control of local assets, to agencies of the centralised welfare state. By 2019, the UK is the most centralised country in the Western world, with 91 pence in every pound controlled and allocated by the Westminster Parliament (Crewe, 2016). The importance of local authorities in promoting health in the community is highlighted by Michael Bennett in Chapter 18.

Historical and political perspectives on the public concern and understanding of the UK health care system were demonstrated at the UK General Election in 2015, when funding for the (NHS) was one of the key issues highlighted by the main political parties. In opinion polls, the electorate's main concerns were related to the shrinking size of the welfare state, the UK budget deficit and protecting the NHS. In attempts to attract voters, each of the major parties used their manifestos to outbid each other by promises to increase NHS budgets. In July 2018, the NHS celebrated its 70th birthday, provoking a focus for the critical issues that currently account for the crisis in this service with the largest number of employees in the UK (also see Bonner, 2018a). In August, Theresa May announced £200 million per week to support the NHS. Although there are questions as to how this money will be found, it provides the basis for a ten-year plan. HealthWatch England is beginning NHS100, an ongoing survey of public attitudes into the perceived needs of the population within the context of technological and medical advances, the changing roles, relationships and responsibilities of individuals and the providers of health and social care. Although people will be living longer, and hopefully will be engaged in meaningful activities in retirement, the diseases of old age could be mitigated by greater individual new technological approaches to monitoring personal health, increased understanding of human development, health and wellbeing, and successful ageing. However, the health care system as reflected in the NHS and growing private organisations providing services to physical and mental health contribute to 20 per cent or less of the personal support of health and wellbeing. Good health and achieving a flourishing and fulfilling life require more, involving the interdependence of the domains outlined in Dahlgren and Whitehead's rainbow model of the social determinants of health (Dahlgren and Whitehead, 1991).

Health and wellbeing in 2020

Currently, social care is provided and funded by local authorities and private funders. The main objective of social care is to help people to live well and happily, and live as long as they can. This person-centred approach is in contrast to the systems that have been developed to support the health care needs of people. Local social services support a wide range of needs including autism, conduct disorder, mental health issues, children, family, working age adults and care for the fragile elderly, dementia and bereavement support. These complex behavioural issues are less amenable to technological monitoring and

support than the clinical dimensions of health. Difficulties in the integration of health and social care systems (see Part I, Chapters 2 and 3) relate to physical, mental and emotional issues that challenge individual, family and community health. Cultural and professional differences between the NHS and social care, traditionally managed by local authorities, are some of the key challenges in the integration of the NHS and social care.

With the ongoing decline in revenue support grant for local authorities (50 per cent reduction within the last five years, leading to 100 per cent reduction by 2020), from central government, the most likely source of funding is from increases in council tax. Elected members and officers running local authorities have a difficult task in balancing the needs of diverse communities within a politically contested environment. Most people are unaware of how social care is funded. This, in part, is owing to the complexity of the service provision and the lack of high-quality information, as is the case for the NHS. There is a need for people to have standardised information and advice (for example regarding care providers and care homes; see Part III, Chapter 12), so that they can make informed decisions about their own and their families care-support needs. There are inequalities regarding the comparative funding of physical versus social care, as demonstrated by the funding from the NHS for cancer care in contrast to the requirement to provide personalised funding of, for example Alzheimer's disease. There is a general misunderstanding of what is and is not provided by the state. The politics of social care was evident when Gordon Brown announced changes to inheritance tax (Death Tax) and Theresa May's capping of costs to 75 per cent of actual care costs (the Dementia Tax). Addressing these politically sensitive issues has not seen any significant changes from the implementation of the ten reports on social care produced during the last ten years. Currently, a Green Paper on social care is being developed, and this will address social care across the lifespan. The successful outcomes of the resulting White Paper will depend on cross-party agreement, relevant approaches to the wide range of social needs, as noted above, and appropriate funding being available. The probability that this will resolve problems with increasing social needs is low, in view of the problems of implementing the Care Act 2014, as reviewed by Paul Burstow (Burstow, 2018). Appropriate funding of social care is important, but the actual needs of people, for example loneliness, depression, problematic substance misuse, obesity and lifestyle disorders, are somewhat more complex than treatments provided for physical health needs. In many respects, these 'wicked issues' (Rittel and Webber, 1973) are not too dissimilar

from those challenges faced by people and communities prior to the establishment of the welfare state.

Health and wellbeing across the life course

In 2020, poverty still remains a key driver of poor health and wellbeing. The relationship between poverty, child abuse and neglect (Bywaters et al, 2016), is associated with domestic violence (Fahmy et al, 2016), human trafficking and modern slavery (Bulman, 2018) and other 'wicked issues'.

An important contribution to the Social Determinants of Health conceptual framework is provided by the work of Michael Marmot and the University College London Institute of Health Equity. One of the nine key messages of the landmark Marmot Review (Marmot, 2010) is that reducing health inequalities requires policy objectives to:

- give every child the best start;
- enable all children, young people and adults to maximize their capabilities and have control over their lives;
- create fair employment and good work for all;
- ensure healthy standard[s] of living for all;
- create and develop healthy sustainable places and communities;
- strengthen the role and impact of ill health prevention.

The current deterioration in standards of living in the UK is apparent from the Human Rights Watch Report (Anon, 2019a) released on 20 May 2019. This accuses the UK government of breaching its international duty of care by 'cruel and harmful policies' that are exacerbating child poverty in Hull, Cambridgeshire and Oxford. The report, commenting on 'a troubling development in the world's fifth largest economy', identifies tens of thousands of families who do not have enough to eat, with parents and schools resorting to food banks to feed their children. Food banks, managed by the Trussell Trust and a range of independent organizations (see Chapter 17), are a common feature of community support for people struggling to survive precarious social situations, impacted in many cases by welfare reform, delayed benefit payments, sanctions and unreliable disability assessments. A recent report in the *British Journal of Nutrition and Dietetics*, into food provided by Trussell Trust and other independent food banks in Oxfordshire, indicates that although food banks are providing a regular source of basic food for an increasing number of families, such provision has poor nutritional value (Fallaize et al, 2020).

The United Nations Rapporteur, Philip Alston, has previously drawn attention to the political context of poverty in children and families in the UK (Anon, 2019b), and attributes these adverse conditions to a UK government that is preoccupied with leaving the EU. The final report was published on Wednesday 23 May 2019. In this final version of his report, Alston accused UK ministers of 'immiseration of a significant part of the British Population', and warned of the worsening prospects of vulnerable people if Brexit proceeds: it 'was a tragic distraction from the social and economic policies shaping a Britain that it's hard to believe any political parties really want'. Alston's comments that ministers had designed a digitised version of 19th-century workhouses, as depicted by Charles Dickens, was rejected by Amber Rudd, the Work and Pensions Secretary, saying that the report was politically motivated. However, the UK government does not have a good track record in dealing with this 'wicked Issue' (see introduction to Part IV). In response to the riots in August 2011, The Troubled Families programme was announced in June 2013 (HMG, 2019), and rolled out from 2015. This was aimed at 'turn[ing] around' 120,000 households, but appears to have run into difficulties. According to the BBC (BBC, 2019), the 'damning' report into this programme was suppressed, and in any case, according to a senior civil servant, was 'window dressing'. Of 56 local authorities, there was a 'lack of obvious effect … across a range of outcomes … within the time frame [18 months] … of the report'. This policy was implemented during the progression of the Children and Families Act 2014 (Kerr, 2018).

The demographic projections of an ageing population present considerable challenges for national and local government. Four independent reviews, and a number of Green and White Papers of the funding of social care, including a Royal Commission and the Dilnot Commission (Dilnot, 2010), have not resolved this demographic crisis. The problems of an ageing population and housing is the focus of Chapter 18. Paradoxically, lower house prices in the North-East have resulted in movement there of an increasing number of people after retirement, and this is also the case for other areas with lower-cost housing. This gives councils with the added liability of councils for increased social care costs (see Chapter 7).

There are both political and health-based connotations for 'taking [back] control'. However, although personal control is an important bio-psycho driver, a sense of coherence, identified by Antonovsky, supported by extensive evidence from Lindström and Eriksson (2010), is central to our sense of identity. This approach, which involves 'head, hands and heart' is being adopted by policymakers and commissioners

of services, as noted in Part IV, Chapter 16. 'Deaths of despair', reviewed by Harry Burns (Part I, Chapter 1), are a sad indictment of our society, and too often are the result of negative sociopolitical attitudes, the flames of which are fanned by social deprivation and social and health inequalities.

In order to achieve the best outcomes for individuals and their communities, local authority leaders should consider the interconnectedness of communities, social networks, resilience and psycho-social health based on an 'asset-based' approach to health and social care (Lindström and Eriksson, 2010). A combination of individual, family and environmental factors can create risk and increase the probability of adverse life events. These can be mitigated by protective factors, an accumulation of which increases the chances of positive effects and resiliency dependent on the level of risk factors.

The paradox of the paralysis of the UK parliament, due to Brexit, is that it is predicted that a significant proportion of 52 per cent of the UK population who voted to leave the EU in the 2015 referendum are those most likely to be adversely affected by the continuing austerity budgets and anticipated downturn in the UK if the UK leaves the EU 'without a deal'.

Developing assets in people and the community

Building on our knowledge of developmental processes across the lifecourse, particularly family and community influences (Lindström and Eriksson, 2010), clearly the more assets that are present within a person's life, the more likely they are to have positive outcomes and the less likely they are to engage in poor lifestyle choices. This use of developmental assets (Rippon and Hopkins, 2015) promotes a holistic, joined-up approach to healthy development by highlighting areas that can be improved in order to thrive. The developmental assets framework provides the possibility of identifying children and young people at risk, and identifies specific areas of support required. The factors identified within Action for Children Research (Anon, 2009) have preventative potential and economic benefit from providing nurturing environment and service provision around specific pathways. Both viewpoints reinforce the value of positive psychology, and the resilience-building effects of positive activities and involvement within communities.

A thriving community results from an individual reaching their potential, underpinned by positive childhood and personal resilience nurtured within a community led by informed elected members

working within local, regional and central government. The Care Act 2014 is a political response to promote wellbeing and make wellness a common purpose of health and social care (Chapter 15). Promotion of this community-organising principle recognises that relationships are critical to a good life. Relationships are also important in the response of local authorities in the provision of services and support for people and their community (see Part III, Chapters 11, 12, and Part IV, Chapter 15).

From a Social Determinants of Health perspective, the interdependence of an individual's assets and their socio-economic environment is 'glue' that promotes health and a healthy community. Community assets are, in the main, managed by local authorities. This book presents a number of challenges to each one of us as we influence local policy by the election of local councils, which are responsible for the selection and activities of council officers.

Maintaining social connections, looking to the strengths and resources of statutory services and promoting partnerships are all central to enabling healthy communities to thrive. However, fiscal restraints in implementing the Care Act 2014, welfare reforms, economic uncertainty with the UK leaving the EU and current perturbations in the UK political system all point to the need for a critical review of community anchors and the evolving role of local authorities.

COVID-19

Following the reporting of a cluster of cases of pneumonia by the Wuhan Municipal Health Commission in China on 31 December 2019, the COVID-19 crisis has brought unprecedented challenges to every family, neighbourhood, local authority and government department in the UK, not to mention a devastating impact on the world economy.

The news on 4 January 2020 of the first recorded case of COVID-19 outside China, in Thailand, was the start of a chain of transmission across the world, with the first cases in the UK being confirmed on 31 January 2020. By 5 March 2020, the first UK death was confirmed, and on the same day England's Chief Medical Officer, Chris Whitty, announced that the UK was moving to the second stage of dealing with COVID-19 from 'containment' to the 'delay' phase. On 9 March 2020, the FTSE 100 plunged by more than 8 per cent, its largest intraday fall since 2008, amid worries over the spread of COVID-19.

Deeply concerned by the alarming levels of spread and severity, and by the alarming levels of inaction, the World Health Organization made

the assessment that COVID-19 should be characterised as a pandemic on 11 March 2020. The next day the FTSE 100 plunged again by over 10 per cent, its biggest drop since 1987, with other markets around the world being similarly affected by the ongoing economic turmoil. The UK government response came in a series of announcements; from advice to work from home if possible and to avoid visiting public places on 16 March, to closing schools from 20 March along with the closure of pubs, restaurants, theatres, leisure centres and other similar locations, and eventually, on 23 March, the Prime Minister, Boris Johnson, announced a UK-wide partial lockdown that was to come into force on 26 March. On 16 April 2020 a three-week extension to the nationwide lockdown measures was announced as the number of confirmed COVID-19 cases in the UK rose to more than 100,000 (see Appendix for a synopsis of the COVID-19 timeline).

On 22 April, the government announced that the outbreak was at its peak but that the UK would have to live with some social distancing measures for at least the rest of the year. By 5 May 2020, the number of recorded deaths from COVID-19 in the UK had risen to 29,427, giving the country the highest number of COVID-19 related deaths in Europe and second only in the world to the USA.

This book, providing a range of different perspectives into 'wicked issues', will I hope stimulate conversations, relationships and partnerships for the public good.

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PART I

Health, social care and community wellbeing

Introduction

Adrian Bonner

In Chapter 1, Harry Burns sets the context of this book by drawing our attention to the decline in life expectancy in the United States (US), United Kingdom (UK) and other European countries since 2014. This demographic phenomenon appears to be related to underlying social and economic factors, leading to 'deaths of despair'. Social isolation and poor labour market opportunities negatively impact on physical and mental health. There are particular concerns regarding increasing levels of premature deaths in younger age groups. In many cases, deaths are due to drug overdoses, suicide, alcohol-related problems and 'external causes', such as violence and accidents. The author of Chapter 1, as former Chief Medical Office for Scotland, has a unique view of diseases linked to contemporary lifestyles (often referred to as 'non-communicable diseases'), which are significantly linked to social, cultural and psychological environments. These social determinants are, to a large extent, influenced by local and national politics. Following the devolution of statutory powers to Scotland (see Chapter 20) and Wales (see Chapter 21), there are quite distinct health and social care policies emerging across UK regions. Burns provides a critique of the hierarchy of needs, proposed by Maslow in the 1940s, highlighting the pivotal nature of self-actualisation and the spiritual concept of cultural propensity, the capacity of which depends on early life experiences of nurturing and attachment, setting the scene for later lifestyle choices and resilience. In contrast to the hard structures developed through health, social and local authority policy implementation, reviewed throughout this book, the soft structural approach, as promoted in Part IV, provides a 'salutogenic' perspective through which health, wellbeing and self-actualisation can be promoted. With reference

to the Improvement Collaborative, developed in Scotland, and the 100 Million Healthier Lives Project, convened in Boston, US, this chapter provides the possibility of positively changing the outcomes of complex systems in health and social care.

Chapter 2, representing the perspectives of the Association of the Directors of Public Health, largely focuses on England, with some comparisons from the rest of the UK. It plots the changing positioning of public health, moving between the National Health Service (NHS) and local government.

The strategic movement, across both developed and developing countries, from concentrating health resources on communicable disease to a focus on non-communicable disease, is a response to modern epidemics of obesity, alcohol-related diseases and the politics of health care. However, communicable diseases can still have major health, social and economic impacts, as demonstrated by the potential pandemic caused by the rapid global of COVID-19 (Coronavirus); see Chapters 2, 3 and 4.

Clearly, austerity budgets have an effect on the health of particular segments of the population, with those people at the lower end of the social gradient being most affected by both quality of the environment and availability of health and social care.

Public Health was incorporated into the NHS in 1974, and then, influenced by the Marmot Review (2010), it was returned to local authorities in 2013. Building on the 'science' of public health, public health professionals have been challenged to develop skills in the 'art' of public health that are required to influence policy change and systems leadership within their wider remit in local authorities.

A review of organisational changes in the delivery of health and social care is presented in Chapter 3. These significant system changes provide a backdrop to current challenges in moving towards an integrated system of health and social care, as presented in Chapter 3. Here challenges, related to NHS services being free at the point of use and their integration with means-tested social care, are discussed. Working in Greater Manchester, the authors show how one of the first UK regions in which health budgets have been devolved to the local authority has allowed the development of governance arrangements and agreed strategic plans across the health and social care sector, to promote relationship building. These developments have been underpinned by politically driven reorganisation, expanded in Chapter 5. The Greater Manchester Partnership has increased the possibility of dealing with the complexity of 'wicked issues' (related to individual and community needs), supported by a Transformational

Fund. The wider determinants of health perspective, as proposed by Dahlgren and Whitehead's 'rainbow' model, have been useful in developing holistic responses; these include considerations of transport, housing and unemployment, among other determinants.

In Chapter 4, David Hunter emphasises the need for partnership working, which has been a long-standing objective of health and social policy. For many years, the NHS and local authorities have been attempting to deal with 'wicked issues'. Issues such as homelessness, disaffection of young people and the ageing society that have complex multiple causes require joined-up approaches by the statutory and third sectors at national and local levels. In 2012, at the time when Public Health responsibilities were transferred from the NHS to local authorities (see Chapter 2), health and wellbeing boards (HWBs) were established in England. The author of Chapter 4 has been involved in reviewing the development of HWBs during recent years. He suggests that, although partnerships have never been out of vogue in the UK, the need for them has never been greater. With few exceptions, HWBs punch below their weight and are not the powerful system leaders that were hoped for. Evidence of their value and impact is negligible, with poor performance indicators and the difficulties in overcoming deep-seated departmentalism and a silo approach, prevalent in government and public services, leaving 'wicked issues' as deep-seated as ever. 'After nearly a decade of austerity, which has contributed to a sharp rise in health inequalities and entrenched the North–South divide, and with the potential fallout from Brexit with as yet unknown but almost certainly negative consequences, the need for powerful HWBs that can bring about real change to improve the lot of ravished communities has never been greater.'

Chapter 1 provides a stark insight into some of the 'wicked issues' confronted by the statutory sectors. The complexities of providing an integrated health and social care system are immense. This complexity is particularly problematic owing to regional sociopolitical differences between UK regions. Political changes, such as devolution of responsibilities to Scotland and Wales and metropolitan areas in England, provide a method of disaggregating geo-specific issues. The system changes within the NHS and between the NHS and local authorities could benefit from greater effectiveness of HWBs. However, to date, there is little evidence of their impact in dealing with complex person-centred needs, especially for those at the margins of communities.

What emerges from this section of the book is the need to consider the importance and effectiveness of partnerships. To address major

resource issues and health inequalities across the UK, there is clearly a need to increase prevention and community-based approaches that take account of both hard and soft determinants of health, for instance by reference to 'salutogenesis' (see Chapter 1), working with the third sector (see Part IV) and focusing on the causative drivers of 'wicked issues', as discussed in Chapter 4.

Aligned with the aims of the book, this section emphasises the need to critically examine the role of public, private and third sector partnerships. The success of such partnerships will depend on the relationships between the various sectors, pivotal to which is the development of trust and understanding between those who manage and implement this central element of the welfare state.

A key determinant underpinning the provision of formal and non-formal support for people in the UK is the state of the economy. The end of austerity and future of the UK with the European Union (EU) and the US is currently unknown. Following the general election in December 2019, the majority Conservative Government has legislated for the UK to leave the EU by the end of 2020. The extent to which privatisation of the health service is used by the UK government in trade negotiations with the US will clearly impact on the hard structures supporting the health and wellbeing of people across the UK.

1

Deaths of despair – causes and possible cures

Harry Burns

Introduction

Increasing life expectancy is an accepted indicator of human progress in a country. Except in times of war, high income countries have experienced many decades of steady growth in life expectancy. Such growth is largely associated with improving social and economic conditions as well as advances in health care. The long-term trend in life expectancy suggests that the determinants of health and wellbeing were improving. However, there are increasing reports that recent years have seen a slowing in life expectancy growth in many countries. Some countries, including the United States (US), the United Kingdom (UK) and several other European countries, are reporting an actual decline in life expectancy over the past few years since 2014 (Ho, 2018).

This chapter considers the possible causes of this sudden change in the pattern of growth in life expectancy. It is likely that a change in the pattern of the social determinants of health underlies this abrupt deterioration. Simply, the authors consider the possibility that social change has produced a decline in the wellbeing of populations in high income countries. They examine how wellbeing is defined and how it is created, and the methods by which societies can improve wellbeing in their citizens are considered.

What has caused the decline in life expectancy?

Some studies have attributed this relative decline in life expectancy to increasing mortality among the elderly from heart disease, Alzheimer's and respiratory disease. Some have suggested that this increase in deaths might be associated with serious influenza outbreaks (Ho, 2018; Kwong et al, 2018). However, increases in premature deaths in the US and the UK have also been seen in younger age groups.

The causes in younger people have been identified as drug overdoses, suicide, alcohol-related problems and external factors, such as violence and accidents. This pattern of mortality strongly suggests that underlying social and economic issues are responsible for this worrying trend (Leyland et al, 2007; Case and Deaton, 2015). Economic insecurity has been suggested as an important influence on what has been described by Case and Deaton (2015) as an increase in 'deaths of despair'.

They used this term to describe the emergence in the US of a marked increase in the all-cause mortality of middle-aged, white, non-Hispanic men and women between 1999 and 2013. This increase was primarily due to deaths from drugs, alcohol and suicide. The authors suggested that these mortality increases are a reflection of the distress that mid-life blue collar workers in the US are experiencing owing to increasing social isolation, poor labour market opportunities and, consequently, poorer physical and mental health.

This picture is very similar to the situation seen earlier in areas of the UK that also experienced collapse of industry and loss of social cohesion as communities sank into poverty. The effect has been closely studied in West Central Scotland, which saw catastrophic loss of traditional industries such as steel and shipbuilding in the decades following the Second World War (Hanlon et al, 2007; Walsh et al, 2017). Slow improvement in life expectancy in Scotland has been accompanied by a relative widening in mortality across socio-economic classes (Popham and Boyle, 2010). Extensive analysis suggests that the problem in Scotland has been caused by increasing mortality among poor, young and middle-aged Scots due to drugs, alcohol, suicide and violence. The pattern seen in Scotland's post-industrial areas mirrors the 'deaths of despair' described in the US.

Increasing poverty, which accompanied the loss of high-quality jobs in the second half of the 20th century, and a series of town planning policies based on social selection caused significant social dislocation and economic upheaval. In effect, Scotland experienced the social effects of austerity many decades before anywhere else.

Reversing the decline in life expectancy seen across several countries will not be achieved by more health care. Increasing mortality from drugs, alcohol, suicide and violence is symptomatic of deeper societal problems. These issues, which seem to affect predominantly poor post-industrial areas, will not be cured by hospitals and doctors. The problem faced by these areas is not too much illness; the problem is a lack of wellness.

Wellbeing – what is it?

The World Health Organization defines health as a 'state of complete physical, mental and social wellbeing, not merely that absence of illness or infirmity'. It is a definition that is often quoted but it is not entirely helpful. It tells us that to be healthy you need to experience wellbeing, but what is wellbeing? It is difficult to find a concise definition.

Wellbeing is subjective. If people feel their lives are going well, they will report a sense of wellbeing. If they feel safe and secure in their living conditions and feel in control of their lives, they will feel well. If they have a sense that their lives have purpose and meaning and, as a result, they have a desire to engage with the world and its problems, they are likely to feel well (Antonovsky, 1979).

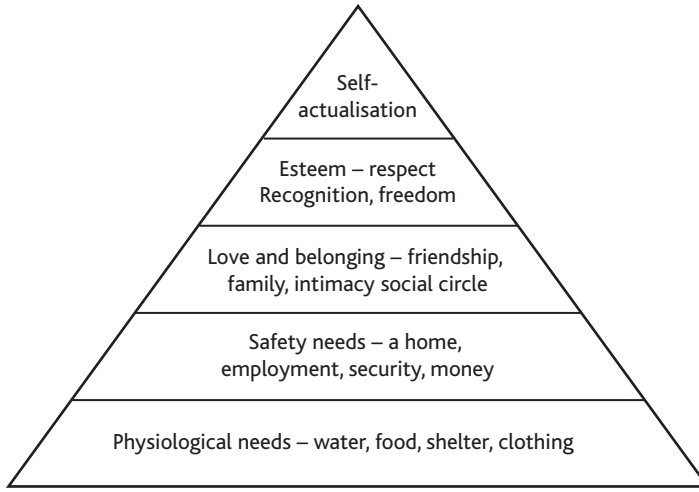
Furthermore, creating wellbeing is not a simple matter. Wellbeing across a society emerges from a complex adaptive system in which many influences interact. Wellbeing is not something that can be created by a single, simple intervention (Cloninger et al, 2012). Yet public policy often relies on such solutions when it turns to legislation to control access to cigarettes or alcohol or sugar-containing beverages. Such solutions may have some effect, but their contribution to broader wellbeing in society is often difficult to quantify.

Conditions that support wellbeing include living in safe and congenial communities. There is evidence, for example, that living close to green space is associated with better health (Ward Thompson and Silveirinha de Oliveira, 2016). Security of housing tenure, access to education and opportunities, and adequate income from that satisfying employment are important determinants of wellbeing, as are the relationships that come from living in a supportive community. All these aspects of society contribute to the wellbeing of citizens.

How is wellbeing created?

There are many theories about how wellbeing in individuals emerges. One of the most influential theories used by public health practitioners to explain the relationship between external influences and positive outcomes is Abraham Maslow's hierarchy of human needs (Figure 1.1) (Maslow, 1943). Maslow was an American psychologist who proposed a theory of health and wellbeing that was based on the idea of serial fulfilment of basic human needs. He suggested that humans perceived needs as a hierarchy and, if they were fulfilled in order of need, humans would attain a state of 'self-actualisation'. Self-actualised people are considered to be those who are fulfilled and doing all they are capable of.

Figure 1.1: Maslow's hierarchy of human needs



Source: Maslow, 1943

The term refers to the person's desire for self-fulfilment. Maslow proposed it as the capacity of individuals to achieve all that they have the potential to be. Famously, Maslow showed these needs as a triangle or pyramid with self-actualisation at its apex, and so suggested that it could only be achieved after other needs had been met.

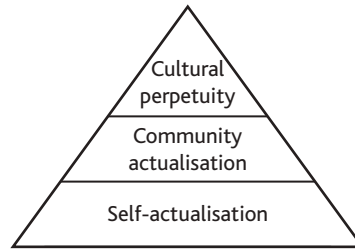
This theory has had significant influence on public health thought and practice. If self-actualisation is regarded as the state of peak wellbeing, the idea is encouraged that self-actualisation cannot occur without attention to issues lower down the hierarchy. If individuals lack wellbeing, Maslow's theory is used to support the argument that poverty, social exclusion and needs must be identified and dealt with before people can function at a level consistent with their full capacities.

However, there is considerable evidence that suggests Maslow was wrong in suggesting this order of events.

In 1938, Maslow visited a Blackfoot Indian reservation in Canada (Blackstock, 2011). There, he learned how the Native Americans sought to preserve a strong, traditional culture. They drew for him a different hierarchy that had as its *base* the need for self-actualisation (Figure 1.2).

If, they argued, young people grew up to feel positive about their lives and in control of their destinies, they could contribute effectively to community actualisation. If, as a consequence, communities were functioning to their full capacity, their traditional cultures would be preserved. Cultural perpetuity was their aspiration. Self-actualisation

Figure 1.2: The hierarchy of needs as suggested to Maslow by the Blackfoot Indians



Source: Blackstock, 2011

for the indigenous people was the foundation of the way in which they preserved their culture, not the end result. This view of self-actualisation seems more plausible. In prehistoric times, it is unlikely that prehistoric *Homo sapiens* would solve all the problems of survival before learning to cooperate and live successful lives in community with others.

Why did Maslow move self-actualisation to the top of his hierarchy? It is difficult to say. It may be that he felt uncomfortable with the more spiritual concept of cultural perpetuity and respect for ancestors described by the Native Americans. He may have wanted to assert the importance of individual decision-making and development, as was being advocated by economists of the time. However, since then, a greater understanding of neuroscience and the biology of stress has given us insight into how and when personality develops. This work suggests that the development of the capacity for self-actualisation depends on the experience of nurture and attachment during very early childhood (McEwen, 2008; Hill et al, 2018).

Unlike Maslow's theory of self-actualisation, which suggests that individuals attain the ability to feel in control of their lives after a series of other conditions have been satisfied, science tells us that self-actualization is an attribute that develops from birth, and is experienced in parallel with and influences all the other stages outlined by Maslow. In order to progress to a fulfilled life, it seems we must learn self-actualisation in early life if we are to progress. Self-actualisation is a means to an end, not, as Maslow suggested, an end in itself. Understanding these processes, therefore, has significance for public policy as it tries to improve wellbeing.

Salutogenesis and the science behind wellbeing

Over the years, salutogenesis has become an established concept in public health and health promotion. The key elements of the

salutogenic model are the focus on supporting the individual's problem-solving capacity and, secondly, developing the capacity to use physical and social resources available to solve the problems encountered.

It was the American sociologist Aaron Antonovsky who introduced the term 'salutogenesis' in 1979. Antonovsky's idea was that we should view the health of an individual as being a point on a continuum from complete ill health (dis-ease) to complete health (ease). His insight was that we should focus on building people's resources and capacity to create health rather than adopt a medical focus on ill health and disease. This concept was based on work he carried out in the 1960s, studying the health of menopausal women in Israel. He found that women who had been exposed to severe stress in early life had poorer health in later life. However, one-third of women who had been exposed to the same severe stress, in this case the Holocaust, had normal health. It seemed to him that those who were healthy had found resources to cope with external stressors, and he set out to understand how this capacity might be created.

Antonovsky evolved the concept that the key factor underpinning wellbeing and the capacity to manage external stressors was the extent to which the individual had developed in early life a *sense of coherence* (Antonovsky, 1993). He defined this as:

> [A] global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic, feeling of confidence that:
> 1. the stimuli derived from one's internal and external environment are structured, predictable and explainable
> 2. The resources are available to one to meet the demands posed by these stimuli
> 3. These demands are challenges, worthy of investment and engagement.

To experience wellbeing, Antonovsky suggested, individuals must feel the world around them as understandable, manageable and meaningful, otherwise they will experience a state of chronic stress. The idea that stress levels are higher in those individuals who do not feel in control over their lives has allowed Antonovsky's ideas to be tested.

The biological consequences of adversity in childhood

The relationship between social and economic circumstances and evidence of altered metabolic processes has been studied in a number

of settings. Children who have experienced neglect and subsequent adoption have higher stress hormone levels than children who have no such history (Kertes et al, 2008). Children born into families at the lower end of the socio-economic spectrum are more likely to have poorer cognitive function and lower educational attainment than children from more affluent families (Hackman et al, 2010).

Brain imaging studies have shown that children who experience neglect or abuse or whose parents have serious mental illness have a pattern of brain development that makes them more emotionally labile and less likely to be able to control impulsive behaviour (McEwen, 2008; Hackman et al, 2010) They become more anxious, aggressive, fearful and more likely to react to stressful situations with poorly thought-out responses.. The more adversity children encounter, the more likely they are to grow up with addiction issues, fail in obtaining employment, engage in partner violence and acquire criminal convictions.

In 1972, researchers in New Zealand began a study of the health and wellbeing of 1,000 babies born in Dunedin that year (Poulton et al, 2015). Forty-seven years later, most of those people are still being studied. Risk factors for poor wellbeing in later life have been identified: low family socio-economic status, low parental education, time in a single-parent family, having multiple caregivers or residential changes, experiencing domestic violence, physical abuse and sexual abuse were all associated with a higher risk of aggression, hyperactivity, conduct disorder, anxiety, antisocial behaviour, mental health problems and lower self-esteem. These children endured longer periods of youth unemployment, and 20 per cent of the group studied accounted for 80 per cent of the criminal behaviour observed.

A study of adverse experiences in childhood carried out in the US also showed a strong association between poor early childhood experiences and risk of violent behaviour as an adult (Felitti et al, 1998). Closer to home, a study carried out in England reported that adults experiencing serious levels of neglect were 14 times more likely than those children not experiencing abuse and neglect to have been a victim of violence, 15 times more likely to have committed a violent crime in the last year and 20 times more likely to go to prison during their lives (Bellis et al, 2014). A study carried out in Wales suggested that 14 per cent of the population had a level of exposure to adverse experiences that would result in them carrying these risks. In addition, the study quantified the longer-term risk of chronic disease in people affected by childhood adversity (Bellis et al, 2016).

It is clear that the ability to feel in control of one's life is largely determined by the circumstances in which people are born and raised. Failure to experience consistent, nurturing parenting impairs children's ability to see the world as structured, predictable and explainable. They are less likely to acquire the skills and insights that allow them to meet the challenges they face in an acceptable way. In short, they do not acquire a sense of a coherent world with which to engage. If we are to tackle the causes of inequity in outcome, we need to create a society that helps young people to feel in control of their lives.

How can societies create health and wellbeing?

Most countries know how much they spend on health care and treating disease. Few countries will know how much they spend on creating wellbeing in their citizens. This is understandable given the subjective nature of the term. For example, spending money creating green space or installing public art might make some people feel well while others are, at best, neutral in their feelings.

There have been some attempts to measure the economic implications of failure to create the capacity for wellbeing in children. In particular, studying the impact of adverse childhood experiences on adult wellbeing has been used to calculate the lifetime economic impact of failure to provide support to families and children. In studying the economic burden of child maltreatment in the United States, Fang et al (2012) estimated the aggregated lifetime cost of child maltreatment in 2008 by multiplying per-victim lifetime cost estimates by the estimated number of new child maltreatment cases in 2008. They estimated total lifetime economic burden resulting from new cases of fatal and non-fatal child maltreatment in the US in 2008 was approximately $124 billion. This cost is approximately equivalent to the cost of chronic disease such as stroke and Type 2 diabetes (Fang et al, 2012). However, more recent estimates of the annual cost of adverse childhood experiences suggest the impact is much greater. Bellis and colleagues (2019) suggest that the annual cost attributable to chaotic childhoods is equivalent to $581 billion in Europe and $748 billion in the US (Bellis et al, 2019).

Without clearly appreciating the impact of their failure to tackle the circumstances that result in a lack of wellbeing in large sections of the population, policymakers will just keep on doing what they have always done – expecting different results. Einstein, it is reported, thought this was a definition of insanity.

Why does public policy fail?

In the 1980s, attempts were made in the UK to make public services 'more businesslike'. Known as New Public Management (NPM), the system focuses on customer service, financial control, value for money and increasing efficiency. Senior managers drive change by setting targets and using indicators and performance monitoring. The wellbeing of the community, being difficult to conceptualise, rarely features in strategic plans or managers' objectives.

Public services tend to focus on people's problems, needs and deficiencies. We design services to fill gaps and fix people's problems for them. Studying many projects that have transformed the lives of people living with socio-economic deprivation suggests that helping people develop a sense of self-efficacy and control are important drivers of wellbeing. Public services do things to people rather than with them. As a result, citizens become passive recipients of services.

The projects that are successful in transforming the lives of people living with socio-economic deprivation are those that help people develop a sense of control over their lives. Public services often undermine the already low sense of self-efficacy and self-esteem of people living in difficult circumstances. Whatever we do to improve wellbeing will involve helping people to take control over their lives.

A method for improvement

Wellbeing emerges from the complex interaction of many factors. It is not something that can be created by a single intervention. The linear thinking encouraged by NPM is unable to take account of the complexity from which wellbeing emerges. Setting targets without understanding the actions required to achieve those targets is certain to alienate front-line workers, who are probably the best informed about the complexity of the problems facing them.

Scotland recently began to tackle complex problems in health using concepts of improvement science. This is an approach that emphasises testing in the field the ideas for change that emerge from practitioners. The results of many tests of the impact of change are quickly spread in order to generate learning about the changes that produce the desired improvements. It brings together the empirical knowledge of people who have to deliver the change and provides them with tools to implement the desired improvements.

Projects begin by specifying a clear and stretching aim for improvement and a measurement plan, and then the practitioners begin

small tests of those changes they think will lead to improvement over a short period of time. As these small tests are refined and successfully implemented, the learning is shared and improvements are scaled up across the system. Implementing this approach requires us to answer four questions.

- What do we want to change?
- By how much do we want to change it?
- By when do we want to achieve the change?
- What method will we use to make the change?

This was the approach used in Scotland to improve outcomes in Scottish hospitals. The Scottish Patient Safety Programme has produced a highly significant reduction in harm to patients and, notably, a 37 per cent reduction in post-operative deaths, largely associated with the regional improvement collaboratives. It is also being used to improve outcomes for children in the Children and Young People Improvement Collaborative. The system was first used in industrial process improvement by W. Edwards Deming. It was then applied to health care in the US by the Institute for Healthcare Improvement in Boston, when it developed its 100 Million Healthier Lives campaign, noted below.

The method is one in which front-line staff identify several interventions that have a small but positive effect on desired outcomes. Taken in isolation, each intervention might only produce a small effect that might not be seen as significant if tested by conventional statistical methods. If, however, we identify 30 small changes that each produce a 1–2 per cent improvement and apply them consistently, we might see a 30–50 per cent improvement. It was this method of concentrating on 'marginal gains' that brought success to UK cycling teams in international events (Pentecost et al, 2017).

Applying improvement methods to wellbeing

An improvement programme aimed at improving wellbeing across a whole society is a formidable prospect. In any such programme, it would be critical to ensure it was designed by citizens working closely with front-line staff from the agencies most closely involved in supporting communities. This work should not be designed by academics and experts advising ministers, who then issue policy papers that they expect front-line staff to implement. It is difficult for people to be committed to a programme that they have had no involvement

in designing. To be effective, the programme design must involve the people being supported and those who support them.

In essence, an improvement collaborative has four stages. First, set a stretching aim for the project. Secondly, agree a set of drivers that will help achieve the stretch aim. Thirdly, identify actions that will implement change in the drivers. Finally, agree the metrics that should be used to assess the degree of improvement.

The most ambitious wellbeing improvement programme currently under way is the 100 Million Healthier Lives campaign. The following description comes from the website that supports the campaign and those involved in it.[1]

This international programme is convened by the Institute for Healthcare Improvement in Boston, US. It brings together community organisations, educational establishments, governments, funders and a variety of organisations that contribute to health and wellbeing. It works to a broad definition of health and wellbeing that acknowledges health is not solely the absence of disease but involves the addition of 'confidence, skills, knowledge and connection'. It goes on to say that health is a 'means to an end – which is a joyful, meaningful life'. This definition is broad and its parameters are difficult to measure. However, it is perfectly accurate and reasonable to suggest that the aim of the project is to enhance the chance that people are able to live a 'joyful, meaningful life'. The only problem is how to do it.

Having set a stretching and worthwhile aim – that 100 million people should be more able to live a healthier life by 2020 – the next question to answer was 'what do you want to change?'.

To shape the list of 'whats', the conveners gathered recommendations from groups of experts working across all the agencies that might contribute to health

Address equity gaps – required for all participants.

1. Help all kids have a great start in life with all the skills they and their families need to flourish from cradle to career.
2. Support veterans and refugees to thrive.
3. Reclaim the health, wellbeing and dignity of indigenous communities.
4. Address the social and behavioural determinants of health across health care, community and social services, with a special focus on vulnerable populations.
5. Make mental health everybody's job, across the continuum of health care, community, public health and social services.
6. Improve access to primary health care for all.

7. Create the best possible wellbeing in the elder years and at the end of life.
8. Engage everyone in improving their own health.

This list involves several high-level aims. The third question is 'how are we going to make the change happen?'. The 'how' list was drawn up based on the extensive consultation.

1. Shift culture and mindset
   - Use storytelling as a strategy to create a change in culture.
   - Develop a culture of partnership.
   - Develop a culture of wellbeing.
   - Develop leaders at every level who are empowered to carry out the vision.
2. Develop workforce strategies – engage students and youth as leaders in the transformation.
3. Integrate peer-to-peer support systems into every relevant initiative.
4. Integrate improvement and change methods at the community level.
5. Use the top chronic diseases in each community and core risk factors to build a continuum of health across home, community, public health and health care.
6. Develop and adopt financing strategies that align funding at the community level.
7. Integrate data across silos (health care, community, public health and social services).
8. Engage employers and businesses to improve workforce health and wellbeing.
9. Transform health care to be good at health and good at care

Each community will develop its own ideas as to how these drivers of improvement can be delivered locally. They test the effectiveness of these ideas and share the results across the network. Shared learning allows identification of many effective interventions that can drive improvement.

The final part of the improvement journey is to establish a measurement framework that allows improvements in health and wellbeing achieved by the tests of change to be identified and recorded. The societal drivers of wellbeing are complex, and it is difficult in any complex system to identify which intervention was responsible for a particular change in outcome. However, measuring improvements in wellbeing is essential in encouraging the many stakeholder agencies involved in promoting improvement to maintain their efforts.

The 100 Million Healthier Lives website gives a comprehensive description of the measurement framework being used in the project. Measurement of healthy life expectancy and assessment of how inequalities in health are narrowing are key measures. Other aspects of improvement are also important. Psychological and emotional development of children and assessment of healthy behaviour changes are also included.

The improvement collaborative approach is a proven method for changing the outcome of a complex system in health and care. The 100 Million Healthier Lives project is an immensely ambitious use of the technique. It is to be hoped that it will produce learning that can be used to transform lives across social and ethnic divides, and make the people of the world kinder and more supportive of those living difficult lives.

Conclusion

Improvements in life expectancy in high income countries have slowed considerably. It is argued in this chapter that this deterioration in health is due to increasing problems with social determinants of wellbeing. The processes by which wellbeing can be enhanced are described and seen to focus very much on the way families with children are supported. Many suggestions have been made for policies that can improve wellbeing, but the most effective seem to be those using improvement science methods. These involve front-line staff working closely with citizens to design, test and implement successful change.

Note

[1] https://www.100mlives.org

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2

The role of English local authorities in addressing the social determinants of health: a public health perspective

Jeanelle de Gruchy and Jim McManus

Introduction

While the term 'social determinants' would have been alien to local government in England at the time of the Public Health Act 1848, the concepts and actions would have been well understood and core to its activities. Parks, decent housing, education, libraries and more have been the staple work of local authorities for many decades. This chapter explores the social determinants of health through the lens of directors of public health in local government – and considers the challenges and opportunities today, and in the years ahead.

The focus is largely on England because of different legislative and constitutional contexts in the four nations of the United Kingdom (UK). At the time of writing, life expectancy is stalling (ONS, 2018) and health inequalities are worsening; with the gap in life expectancy between the richest and poorest areas of England and Wales widening over the past decade (ONS, 2019).

The conditions that create good health are more social than personal (Marmot, 2010). While genetics, individual behaviour and medical services, such as the UK's National Health Service (NHS), contribute to our health outcomes, the dominance given to these factors is more rooted in cultural and ideological prejudices than evidence. These drivers are over-represented when it comes to public health policy and investment decisions.

Health care contributes a significant but small proportion of the public's overall health – and in the UK, the NHS is free at the point of need for all. It is the unequal social, economic and environmental circumstances throughout a person's life course that contribute to