

deliver public  
inequalities need leadership

Co-production for  
health: a new model for a  
radically new world

Building new approaches  
to delivery to achieve  
better health outcomes  
at the local level

local commissioning

partnerships

communities

health

model

local

approach

clear

transitions

outcomes

change

support

FINAL REPORT  
OF A NATIONAL  
COLLOQUIUM  
DECEMBER 2011

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# Message of support for the Colloquium

**“** *The public health challenges we face as a nation – including from obesity, health inequalities and major health threats – demand a new approach. We need to reach out to communities with a locally led public health system that is underpinned by expertise and real political priority.*

*I'm delighted with the enthusiasm shown for this approach. There is a real commitment across local authorities and the public health profession to improve the health and wellbeing of our communities.*

*I am sorry that I cannot be with you today, but I am delighted to offer my support to an occasion that brings together so many of the leaders of the new system as you work to identify innovative approaches to better health.*

*The title of your event is absolutely right; the only way to deliver a successful transformation of public health is to bring together the full potential of local government, the NHS and our communities. Well done to everyone attending for their hard work, commitment and seeing this as an opportunity to change people's lives.*

*I wish you well and look forward to seeing your report.*

**”**

**ANNE MILTON,  
PARLIAMENTARY UNDER-SECRETARY OF STATE FOR PUBLIC HEALTH**

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# Executive Summary

A National Colloquium was held in November for an invited audience of public health, primary care, and local authority leaders. The summit considered how organisations could start to use the new arrangements for public health and commissioning positively at the local level to deliver better health outcomes and a reduction in health inequalities in the context of budget constraint. The Colloquium was organised by Solutions for Public Health (SPH) working with partner organisations, the Chartered Institute of Environmental Health (CIEH), the Association of Directors of Public Health (ADPH), the NHS Alliance and the Association of Directors of Adult Social Services (ADASS).

Discussion at the Colloquium focused on the necessary components of a new co-production model for public health, addressing the following questions:

- How to exploit the opportunities created by the integration of public health and local government?
- How to maximise the new structures, approaches and democratic accountabilities to deliver public health outcomes and a reduction in inequalities?

And drawing out contributions on leveraging the transition to:

1. Maximise the new commissioning structures to improve health outcomes and reduce inequalities when money is tight
2. Establish what is needed to deliver evidence informed decision making for public health
3. Use the new partnership opportunities to do things better
4. Maximise leadership roles in the new system

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# Key messages

The key messages emerging from the discussions during the day were:

- Use the transition to start to develop a new co-production model for health and wellbeing.
- The model will fail without elected members' understanding and buy-in – they need to be at the helm.
- Establish focused, agreed priorities which have meaningful outcomes for all partners.
- Put in place a mechanism and infrastructure to ensure effective delivery.
- Use intelligence dynamically, creatively and succinctly and in relevant forms for different audiences.
- Promote an asset based approach to communities to understand and harness their assets and resource.
- Adopt a new approach to partnership and leadership whilst building on what has worked.
- The public health workforce has to change – a new business model needs adopting that is pragmatic, practical and delivers solutions to commissioners and providers.
- Build public health capacity across a whole range of workforces to deliver interventions at industrial scale.

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# Necessity is the mother of all invention – creatively delivering change together

Health inequalities are widening and there is a shared need to address the social gradient for health in new ways if public sector and other providers of health and wellbeing services are not to become swamped and unaffordable. National policy direction and public sector reform have created a new dynamic at the local level to enable stakeholder organisations to review how improved health, in its widest sense, can be delivered with more efficient, more equitable and more sustainable outcomes, all in the context of less available funding. In many parts of the country, work is underway, in a variety of sectors – local councils, communities, voluntary sector, public health teams, health services, clinical commissioning groups – to test ways, using the new levers and changes in the system positively and creatively, to achieve change.

.....  
“The imperative is to move together now to a new model – act now and do what you can!”  
.....

Solutions for Public Health (SPH), with its Colloquium partners, the Chartered Institute of Environmental Health (CIEH), the Association of Directors of Public Health (ADPH), the NHS Alliance and the Association of Directors of Adult Social Services (ADASS) saw merit in bringing together thought leaders, from different sectors around the country, to tackle these issues, share experiences of the new ways of working and explore ideas for what will work in the new world (see Appendix 2 for full list of delegates).

There was consensus across the agencies of the benefits of taking a holistic approach to delivery of health outcomes at the local level and what is needed to be in place to make this happen. Local Government is the place to orchestrate partnerships to drive health and wellbeing. This is a given. There are benefits for individual's health, for community engagement, capital and capacity and for partner organisations to deliver shared outcomes, offsetting demand and cost.

This report is issued to stimulate further thought and ideas, help clarify objectives for local leaders and shape action in new ways whilst organisations are still in transition and options for delivery of new systems are still being considered.

## Setting the context – The widening gap

A radical new approach is essential because of widening health inequalities in the context of much less funding in the public sector. Dr Mike Grady from the Marmot team set the context.

The Marmot Review (Fair Society, Healthy Lives<sup>1</sup>) highlighted a 17-year difference in disability free life expectancy in England between those at the bottom of and those at the top. It is estimated that two thirds of people aged 68 and over will have a life-limiting illness in the future.

<sup>1</sup> Marmot M. (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010. The Marmot Review, 11 February 2010

.....  
“A radical joined-up approach with give and take from all stakeholders is the only way forward.”  
.....

Just targeting policy effort on those in the bottom tier will not be sufficient to shift the steepness of this gradient. Actions must be universal but with an intensity and scale that is proportionate to the level of disadvantage (proportionate universalism). One way forward is to take a life course approach. Economic disadvantages are reinforced from one generation to the next. For example, educational opportunities impact on later life chances in personal wealth and health status. We need to work on accessing key stages across life, starting with children and those arriving at school less able to benefit from education. Equally, unless action is taken with those aged 16–24, there will be a lost generation who do not work, and will not know how to.

There is growing evidence that, if you engage with people in disadvantaged communities to take control, their self esteem, confidence and health and wellbeing improves and, thereby, their ability to change their life style. To do this effectively they need to be at the top of their game.

A number of Health and Wellbeing Boards are using the 6 Marmot policy objectives to drive their Health and Well being Strategies:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

.....  
“We must use Marmot as the compass to guide our health and well being strategies.”  
.....

The Marmot Review confirmed the Wanless<sup>2</sup> findings that the health service will be unaffordable in 20 years unless fully engaged communities are achieved, and are empowered. Local government is the place to orchestrate partnerships to drive health.

It is even more important in a recession that we have a focus on health, wellbeing and resilience. If we do not, public services will be overwhelmed with demand. Individuals need to be empowered as individuals and communities to support each other and complement whole system work. This is not the same as just saying people have to take personal responsibility. The task for local policy makers, commissioners and local stakeholders is to create the conditions in which they can do this.

2 Securing Our Future Health: Taking a Long-Term View. The Wanless Report, DH, 1 January 2002; Securing Good health for the Whole Population. Final Report, HM Treasury, 25 February 2004

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# Using the transition to start to develop a new co-production model for health and wellbeing

Creating a functioning co-production model based on social justice and with a revamped approach to the public health workforce means ditching the silo/single organisation focus with individual funding streams from the past. We must move to create a stronger shared, broader focus on health for the future. Organisations can use the transition now to establish the building blocks for this.

## **1. FOCUSED, AGREED PRIORITIES WHICH HAVE MEANINGFUL OUTCOMES FOR ALL PARTNERS**

An early step is to establish, locally, shared priorities across all partners on the Health and Wellbeing Board that will make a difference to overall health outcomes. This will also assist each partner organisation in achieving their own objectives including financial savings. Alcohol misuse is a good example because of the adverse impact it has on the environment, communities, employment, excess hospital admissions. The Marmot approach to intervention at key stages in the life course is also a potential unifying way forward.

The trick is to create policy direction all partners can support, see the place of their particular contribution and how collective engagement will bring better outcomes across the whole population. There is an economic as well as an epidemiological case to be made.

Locally, key partners need to be identified and, in county council areas, mechanisms for securing effective engagement with district councils. Boards need to be clear on the appropriate geographical level to get decision making right – and the right partners on board at each level. What is best looked at once over a large population (economies of scale and avoidance of duplication) versus what will bring greatest dividends by being done at the very local, neighbourhood level.

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## **2. DELIVERY MECHANISMS IN PLACE**

“Integration does not just mean click and drag!”

There needs to be a mechanism and infrastructure beneath Health and Wellbeing Boards to ensure follow through of effective delivery. This might include task and finish groups with members well versed on specific issues so that they can take informed cabinet decisions. Consistent evaluation, monitoring and performance management of all contracts and programmes will be key.

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## **3. USING INTELLIGENCE INTELLIGENTLY**

An aide to shared understanding is relevant information and evidence of what works. The Joint Strategic Needs Assessment (JSNA) is a well established source of information but the intelligence within it is not always presented in ways that are timely, easily digestible or

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.....  
“Communities are a key resource. Let’s actively engage with them to harness their potential for driving the change.”  
.....

relevant to the audiences who need to use it. Moreover, JSNAs currently do not always access the wealth of data available at the local level. JSNAs of the future need to link with intelligence held, for example, by the fire and police services as well as the whole range of local government departments. Insufficient use has also been made of the wealth of qualitative intelligence held within neighbourhoods and communities.

Intelligence has to be used dynamically, creatively, succinctly and in relevant forms for different audiences. The move of NHS public health teams into local authorities can help with translation of intelligence from a range of sources but only if they adopt a different approach which is perceived as less academic, more pragmatic and focused on practical solutions.

#### **4. AN ASSET-BASED APPROACH TO COMMUNITIES**

If communities, and individuals within communities, are to be empowered they need to feel they are shaping their own futures. Local authorities already have extensive networks with communities. We need to use communities positively to understand and harness their assets and resource, particularly around personalisation of budgets. There is also much statutory bodies can learn from the approach of the voluntary sector in securing effective local engagement.

#### **5. NEW FUNDING MECHANISMS TO DRIVE CHANGE**

There is no point in spending public money on what does not work. Not only is this wasteful, it does not deliver the best outcomes. There simply is not the funding to do this in the future. Health and Wellbeing Board partners will need supporting evidence of:

- where investment in agreed priority areas will make a difference to health outcomes when, modelled in the short, medium and longer term;
- where and when savings realistically can be achieved when modelled in the short, medium and longer term;
- long term impact on the health of populations of the downsizing of budgets.

This could entail pooling arrangements, refocusing existing budgets, disinvesting or the decommissioning of services. Creating cogent narratives around this which are meaningful to all partners and the public will be crucial to successful implementation. Aligning strategy to on-the-ground commissioning and project work is essential as is securing partner commitment to deliver change through commissioning and providing arrangements.

Providing boards and partners with ready access to public health skills will ensure evidence is tailored to local situations and leads to pragmatic decision making. Decision makers need to know the strength of evidence about what works but also advice on how to proceed where current evidence is weak.



## 6. THE MODEL WILL FAIL WITHOUT ELECTED MEMBERS' UNDERSTANDING AND BUY-IN

.....  
"Every councillor  
could be a local  
advocate for health."  
.....

All are agreed that the new arrangements will only work if elected members are fully on board and committed. They are in the driving seat. The reforms present an opportunity to secure their engagement in more productive ways and create new champions for health and wellbeing. Local councillors are, after all, in touch with local communities, know and understand local issues and the local economy, and what can realistically be done. The new arrangements bring opportunities for forging closer links between GPs and members and between the public health workforce and members. Once again, it is crucial to create relevant narratives and understanding for members about how, through effective use of new powers and duties in councils, they can make a real difference to health and wellbeing. Members also have key links into commerce and the business sector, another fruitful area for engagement for health, especially in improving health in the workplace.

## 7. A NEW PARTNERSHIP AND LEADERSHIP MODEL

We need a new approach to partnership and leadership to make this work whilst retaining useful existing assets (for example from the Local Strategic Partnerships) where they have worked. If local change is to be delivered, partners will need to support each other in implementing difficult decisions. There is interdependency, a need for mutual support and a readiness to share for the public good. There is a need to share accountability for decisions taken together at the strategic level as well as in the context of good risk management and building in contingencies. This is particularly important during the transition when organisations must continue delivery but, at the same time, put new arrangements in place. Health protection arrangements are one example where the local system for the future is not yet fully clear but where there is a key need for local organisations to work together now in the transition to manage risk. Organisations will need also to ensure risk can be managed safely to allow new developments to be tested and implemented.

There are new leaders for health in the system and new opportunities for joint working such as GPs with Adult Social Care over service redesign and balancing commissioned programmes with personalised budgets. Partners are currently at different stages in the development process. This needs to be recognised.

The Director of Public Health (DPH) has a key part to play in facilitating a new style of leadership and empowering others to take on leadership roles for health. The traditional model of a Director of Public Health as the sole advocate and champion for health must be consigned to the past. We need a new conceptual model for the new environment with the DPH working corporately alongside their colleagues in the local authority. Support should be in place to help those who wish it in adapting to this new style of leadership.

## 8. THE PUBLIC HEALTH WORKFORCE HAS TO CHANGE

We need a radically new approach to the public health workforce that gets beyond the view that only those who are fully trained can deliver public health. It will also need to refocus the work currently delivered by those that are already trained. Placing NHS public health teams within local government is not "click and drag".

We need to start with a new business model for public health which is based on how technical and leadership skills can assist and add value to councils and CCGs in delivering their outcomes but in different ways. The language and approach need to change. The skills in translating complex information and evidence into meaningful recommendations need honing. Local commissioners need pragmatic solutions based on the best evidence available. They need to know the implications and impact of different commissioning decisions.

Public health professionals have been accused of being too purist. Decisions for the future must be practically based. Public Health may well be an advocate for health but it also needs to be seen as a service to commissioning functions rather than an empire in its own right. It does mean a change in style to one that is more facilitative and one which seeks outcome delivery through others. These are new roles and ways of working and people will need help and support in adapting to them.

## **9. BUILDING PUBLIC HEALTH CAPACITY ON AN INDUSTRIAL LEVEL SCALE**

The new opportunities presented are considerable, not least in being able to engage with and work closely with a range of departments in local government and, through new duties to be placed on local authorities, with CCGs.

Achieving public health outcomes cannot rest with a relatively small professional specialist and practitioner public health workforce. A key advantage of the changes will be the ability to foster closer working with, and active engagement from, public health practitioners in the local government and primary care workforces such as environmental health officers, pharmacists and health visitors.

To make the new model work many more people need to have core public health skills and an awareness of public health whether it is the social or health care workforce, those working in housing, leisure and planning or in the voluntary sector and communities. There are examples now round the country where mandated basic training in health is delivering benefits in early referrals to services. "Every contact counts" needs to be the mantra for all providers of health and social care. This will not happen without a focused local strategy, investment and development.

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# Conclusions

We firmly believe co-production is the best way to deliver better health and wellbeing outcomes at the local level in a tough financial climate. We are not claiming it is easy to do and we do not as yet have all the answers, particularly about future interfaces between some new structures at the supra-local level. Enough is known, however, to start the ground work in relationship building, shared priority setting and changing the way organisations at the local level work together, harness available assets together, and behave towards each other.

A co-production model presents the best use of available expertise and new commissioning and partnership arrangements. The take-away headlines for organisations from the day were:

- Don't wait. Act now on what you know already and what you can do.
- Start with building local relationships.
- The Marmot Review is more relevant than ever. Use the six Marmot policy objectives as the foundation for strategic partnership working.
- Take a positive asset based approach to engage with and work with communities using them as a resource and source of qualitative intelligence and evaluation of what works.
- Develop a new local model and business case for public health, ensure roles and expertise are in line with outcomes needed and maximise contributions from all stakeholders.
- Be flexible in approach – one size will not fit all.
- Maximise new levers in the system to create something different and use the Health and Wellbeing Board to move from a silo approach to strategy and implementation.

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# Partner Perspectives:

**SPH** – Change is happening. Public Health is an essential multidisciplinary discipline which can make a substantial contribution, using technical skills and leadership qualities to reducing health inequalities and improving health. To do this, however, it needs to embrace change positively and adapt its skill base and leadership approach to fit with new challenges and circumstances.

**NHS Alliance** – The Alliance is committed to general practice commissioning and for GPs to take more responsibility for improving the cost effectiveness of the NHS. Unless everyone – frontline staff, local communities – is fully engaged, it is clear that health outcomes will not improve to the extent needed. Equally, if local authorities are not fully on board with the health agenda, there will be no short term gains to offset the longer term return on investment in health improvement. Clinical Commissioning Groups (CCGs) will need to connect with public health, local authorities and their local populations. Public health, in particular, needs to be clear on its offer to CCGs who will need help with the authorisation process. The focus is on building relationships at the local level.

A key change is to move to a co-production model, building on local assets and empowering people to engage on health. Statutory organisations will not be able to deliver public health outcomes on their own so who else is out there ready and willing to help; how can we build local networks and use front line workers to support them? The stakeholder approach in this model should be “how can I help you with your outcomes?” not just “how can you help me with my outcomes”. This will need a new style of facilitative leadership.

**ADPH** – The Association is positive about moving public health into local government. There is still work to be done in making a whole new system work, linking Public Health England with the role of Directors of Public Health and teams in local government and supporting Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board to maximise scarce resources and avoid duplication. New arrangements will mean public health teams working in new ways to seize opportunities, working with local authority members and officers. A key focus will be to ensure those who are further on in the process help those who are at the start of transition – learning the lessons, providing support.

**ADASS** – Local authorities are about commissioning and shaping not providing. They also have experience in decommissioning and moving services into communities. These skills are valuable to colleagues working in the health service.

A plea, however, not to get bogged down in process but look at the real strength in doing things differently together. There are many natural allies of public health within local authorities beyond environmental health – the Director of Adult Social Services, for example, shares common ground in addressing inequalities and community needs but other allies in terms of their potential impact on health are housing, children’s services, planning, leisure, so use them. Local authorities are positive about the changes but not clear about the whole landscape and may need help in understanding this. Local authorities have a strong tradition of engaging with individuals and communities. Parish councils can also make a contribution. What is needed is alignment of outcomes.

Local authorities are, however, not alike. They differ in size, shape, political complexion. There needs to be an element of pragmatism about what works best locally. The new world of public health will, therefore, be political. A key need is to understand fully the funding envelop and opportunities that will exist between local government and public health jointly to deliver the offer.

**CIEH** – The step change we need in public health delivery will only happen if we do it together and if it is linked to a social justice agenda. The Health and Well Being Board will be the cockpit for making decisions in partnership with CCGs. Individual organisational budgets will be insufficient to make a difference. We need to add the public health ring-fenced budget to what NHS and local government are already doing, drawing in outside organisations, to blend resource use to improve health outcomes.

We should not forget the complexity of two-tier arrangements with one third of the country covered by county councils. The biggest workforce for environmental health is in the districts. They are ready and willing to be engaged.

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# Appendix

## 1) THE PRESENTATIONS AND VIDEO FOOTAGE

You can view some of the highlight presentations at [www.sph.nhs.uk/lgcolloquium](http://www.sph.nhs.uk/lgcolloquium)

Marmot Review: Opportunities to reduce inequalities in the new public health context – presented by Dr Mike Grady

Download presentation at [www.sph.nhs.uk/m\\_grady.pdf](http://www.sph.nhs.uk/m_grady.pdf)

Politics, people and places: England's new public health services from April 2013 – presented by David Kidney

Download presentation at [www.sph.nhs.uk/d\\_kidney.pdf](http://www.sph.nhs.uk/d_kidney.pdf)

Using the new commissioning structures to improve health and reduce inequalities when money is tight – presented by Dr Chris Packham

Download presentation at [www.sph.nhs.uk/c\\_packham.pdf](http://www.sph.nhs.uk/c_packham.pdf)

Wigan: Healthy Lives, Healthy People? Making Marmot Real for Real People – Intelligence led Decision-Making – presented by Dr Kate Ardern

Download presentation at [www.sph.nhs.uk/k\\_ardern.pdf](http://www.sph.nhs.uk/k_ardern.pdf)

Public Health & Local Government: An ADASS Perspective – presented by Glyn Jones

Download presentation at [www.sph.nhs.uk/g\\_jones.pdf](http://www.sph.nhs.uk/g_jones.pdf)

Maximising the Leadership Role of the DPH – presented by Jim McManus

Download presentation at [www.sph.nhs.uk/j\\_mcmanus.pdf](http://www.sph.nhs.uk/j_mcmanus.pdf)

Co-Production of (Public) Health – presented by Professor Chris Drinkwater

Download presentation at [www.sph.nhs.uk/c\\_drinkwater.pdf](http://www.sph.nhs.uk/c_drinkwater.pdf)

## 2) WORKSHOP ATTENDEES

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<b>Chair:</b>	Alison Hill, Solutions for Public Health (NHS)
<b>Speakers:</b>	Dr Mike Grady, Senior Research Fellow, Marmot Review Team
	David Kidney, Head of Policy, Chartered Institute of Environmental Health
	Dr Chris Packham, National Clinical Commissioning Lead, RCGP Centre for Commissioning
	Dr Kate Arden, Executive Director of Public Health, Borough of Wigan
	Glyn Jones, Public Health Lead, Association of Directors of Adult Social Services
	Jim McManus, Joint Director of Public Health, Birmingham City Council & Birmingham PCTs
	Professor Chris Drinkwater, President and Public Health Lead, NHS Alliance

**Delegates:**

Frank Atherton	Association of Directors of Public Health
Michael Attwood	SPH Associate
Susan Biddle	Local Government Improvement and Development (LGID)
Karen Bollan	Independent
Jean Bradlow	Independent
Kim Carey	Cornwall Council
Paul Clark	Harrow Council
Councillor Michael Cooke	Leicester City Council
Jake Eliot	National Housing Federation
Karen Foster	Solutions for Public Health (NHS)
Nick Georgiou	Solutions for Public Health (NHS)
Ian Gray	Chartered Institute of Environmental health
Dr Nicholas Hicks	NHS Milton Keynes
Paul Jennings	NHS West Midlands
Ian Kedge	Lewes District Council
Kate Kennally	London Borough of Barnet
Rita Lally	Buckinghamshire County Council
Jane Leaman	Freelance
Tony Macklin	Port Health & Public Protection Service
Ms Janet Maxwell	NHS Berkshire West
Alyson Morley	Local Government Group
Steve Miller	Newham Council
Nick Raper	Outcomes UK
Don Sinclair	Solutions for Public Health (NHS)
Chris Spencer	SPH Associate
Nicola Stevenson	NHS Confederation
Janice Steed	LeaderShape
Marcie Taylor	Nottinghamshire County Council
Clare Vollum	Age UK
Steven Wibberley	Macmillan Cancer Support
John Wilderspin	Department for Health
Colin Williams	Newcastle City Council
Jenny Wright	Solutions for Public Health (NHS)

# integration

“Integration does not just mean click and drag!”

# click and drag

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