



Raising Health

Organisational options
for delivering improved public health

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Contents

1. Introduction	1
2. The Context	1
3. The <i>Raising Health</i> Design	3
4. Simulation Outcomes	5
4.1 Organisation and leadership	5
4.2 Establishing priorities	6
4.3 Interests and incentives	7
4.4 Freedoms and levers for change	8
4.5 Public engagement and individual empowerment	8
5. Challenges to Raising Health: some conclusions and solutions	10
5.1 The delivery platform	10
5.2 Responsibilities and accountabilities	10
5.3 Prioritisation frameworks	11
5.4 Performance management systems	11
5.5 Public health leadership and capacity for delivery	12
5.6 The evidence base	13
5.7 Levers for change	13
6. Options for a Public Health Delivery Platform	14
6.1 Responsibility and accountability	14
6.2 National level	17
6.3 Regional leadership	17
6.4 Local delivery	17
6.5 Performance management	18
6.6 Leadership, management and delivery	19
6.7 Levers and incentives for raising health	20
7. Conclusions	22
Appendix 1: Definition of 'Public Health'	23
Appendix 2: The <i>Raising Health</i> Issues	25
Health Service Provision	25
Health Protection	25
Health Improvement	25
Appendix 3: Asset Mapping	27

1. Introduction

'*Raising Health*' was the title of a project commissioned from OPM (the Office for Public Management) by the Faculty of Public Health. The Faculty thanks the Department of Health for England, The Health Protection Agency and The Health Development Agency for their support of this project. The aim of this work was to explore how the wide range of resources that could potentially contribute to improving public health could best be integrated, focused and applied.

These resources can be found at different organisational levels – within discrete areas or neighbourhoods, across municipalities and at regional and national or even international levels. A trigger for the *Raising Health* initiative was recognition of this complexity and of the potential for improving health outcomes through greater integration of these resources, both *horizontally* between the various bodies operating at a single level and vertically between those different levels. This report explains the context for and approach to *Raising Health*, summarises the main learning points from the work and recommends options and actions to address current issues and constraints to improving public health.

2. The Context

Raising Health could not have been more timely. It took place just after the launch of the Wanless Report¹, which highlighted the multiple contributions that can be made to public health – by employers, the public services, communities and individuals as well as the government. Wanless also promoted a 'fully engaged scenario' in which individuals have greater awareness of the factors that influence their health and are actively involved in their own health and well-being.

Also just before the event John Reid, the Secretary of State for Health, launched a public consultation - 'Choosing Health' – about improving public health. The consultation document acknowledges that central government, local government, public sector services, individuals, the public, industry, businesses, media and voluntary and community organisations all have an impact on people's health and need to be involved in some capacity. The consultation asks about the best ways of providing people with the information, encouragement and support to make healthier choices.

There were two more fundamental developments that made *Raising Health* timely. The first is the growing public awareness of - and interest in - wider health issues. The consistent media coverage of health improvement illustrates that there is an appetite for a wide-ranging public debate about how health can be improved and who is responsible for improving it.

Second, the place of *health* (as opposed to healthcare) within the government's programme of NHS reform had begun to change. There have been three 'reform' phases thus far with phase one about setting targets and establishing what was expected from the NHS, phase two about focusing on delivery through modernisation and maximising the capacity and outputs of the NHS and phase three about focusing on individualising services for people through the mechanism of

¹ *Securing Good Health for the Whole Population: Final Report*, Derek Wanless, February 2004

choice in order to support service reconfiguration and change the relationship between service providers and service users.

The next phase is about outcomes - a gradual shift away from measures of inputs and processes to measures of outputs and 'results'. The re-emergence of public health as a policy issue is entirely consistent with this focus. The theme woven into the Wanless report and recent Ministerial speeches is that improved health outcomes are most likely to be achieved through greater engagement of individuals in their own health status, actively influencing the things that determine their quality of health and wellbeing. The ministry leading the debate is the Department of Health, not of health 'care' nor of health 'services', and it is clear that public health and its improvement cannot be the sole responsibility of the NHS. It requires a new relationship between the State and individuals and a new way of organising and managing our resources across the sectors to deliver improvements in public health. How best to do this was the question at the heart of the *Raising Health* project.

At the outset we needed we needed a definition of public health and we used the Faculty of Public Health definition² in order to ensure that we kept a broad approach that recognized the range of health determinants and diverse spectrum of agencies, bodies and authorities that can influence those determinants are numerous.

² See APPENDIX 1: Definition of Public Health

3. The *Raising Health Design*

At the heart of *Raising Health* was a large-scale behavioural or open simulation. This was the only way we could model the complexity of relationships and interests that have an interest in - and influence over - the health of the public. that brought together managers, professionals and decision makers from across England and drawn from all parts of the public health spectrum for a two-day event. OPM's simulations assume that what happens in complex systems is the outcome of negotiation and bargaining – both formal and informal – between key players and stakeholders, which are in turn influenced by national, professional, institutional and personal interests. As in real life, open simulations allow any conventions, structures and informal rules to be renegotiated. The rules that apply in the simulations are the ones that already govern the players in their everyday work, such as legal obligations, regulations on professional conduct or the constraints governing how public money can be spent. It is important to reinforce the point that this was not a role-playing exercise. Participants worked in their real-life roles and used their acquired judgement about how they or their organisations would react to the circumstances that emerge as circumstances emerge in the play.

The simulation was 'sited' in a realistic but imaginary geographical 'patch' based on a real county in England - with its constituent public sector organisations and links to current national agencies and regulatory bodies. This 'patch' was called Scarpiashire.

The county of Scarpiashire contained both urban and rural areas and some smaller towns and villages. In the health arena, the area comprised a strategic health authority, two primary care trusts (PCTs) one of which shared its boundaries with the Unitary Authority of Tosca. Scarpiashire also had an acute trust, and a foundation hospital. Scarpiashire County Council oversaw part of the patch but within its geographical boundaries was the city of Tosca with its own council and a university. National players engaged included the Department of Health, the Health Protection Agency and the Health Development Agency.

Before we began the simulation itself we asked the participants to undertake an 'asset mapping' exercise. Essentially this involved the different organisations and agencies represented in the setting out their understanding of their and others' responsibilities and accountabilities for public health and the resources and levers at their disposal. The outcomes of this work are described in Appendix 3.

The next stage was to ask the participants to test the structural and behavioural dynamics of a the patch as they sought to improve public health. As a simplification of real life, participants were given a limited set of issues that affect the public's health in urban and rural communities. These fell into three categories: health protection, health service provision and health improvement. A summary of these issues is provided in Appendix 2.

In order to 'animate' the simulation we constructed around a hypothetical central government initiative which required communities to bid for '*Raising Health Pathfinder*' status. The

communities represented in the simulation were invited to put forward individual or joint bids that explained:

- How they would bring together current structures, processes and assets both at local level and from national contributions to address the issues flagged up in the simulation?
- What levers and/or freedoms they would need to support the above.
- How they would satisfy a set of evaluation criteria that included the following:
 - Capacity to reduce health inequalities and improve overall health status
 - The speed with which those reductions and improvements could be achieved
 - Sustainability of the interventions and outcomes
 - Cost effectiveness
 - Political and public acceptability
 - Degree of disruption

The successful *Raising Health* bids were promised pump-priming money but this was not available for direct service delivery - it was only available to support the transition from current organisational arrangements to the new proposals. The bids were also given a commitment that any reasonable freedoms they sought would be supported. An evaluation panel, including representatives from the Department of Health, Faculty of Public Health and CHAI, monitored progress, heard presentations of the bids from the participants, and provided feedback.

The idea of this initiative is that it would provide a focus for participants to engage in conversations about how they would all work in concert to improve public health. The idea of the 'freedoms' was to stop them being restrained by current formal or informal conventions about responsibilities, roles and funding and to think afresh about how things might be best organised.

4. Simulation Outcomes

A number of issues emerged as helping and hindering participants in preparing their bids during the simulation. This section describes a number of key themes and issues and their impacts on the participants.

4.1 Organisation and leadership

A general point to emerge was that it provided difficult for players within Tosca and Scarpiashire to mobilise the range of contributions to *Raising Health* for their area and to engage with bodies operating at regional and national levels.

- **Whose role is it anyway?** Both local authorities in the simulation (Angelotti County Council and Tosca City Council) took time at the beginning to consider whether they had any responsibilities at all for improving public health. Initially, this was seen as an essentially NHS concern. The financial incentive and kudos of the *Raising Health* bid made some difference to the local authority willingness to take part. However, the money seemed more important as a motivator than the outcomes that could be achieved.
- **Public health or public illness?** Within the health community, PCTs took an early lead in considering how the public health issues would be addressed. This was seen as their home ground.
- **The role of acute trusts.** Interestingly, PCTs did not recognise the acute hospitals as having a significant contribution to make beyond their interests in health service provision. Despite being marginalized and caricatured as being only interested in sickness, the acute hospitals were keen to be involved in local action to improve public health and in putting together the *Raising Health* bids. Their role as large employers was a significant factor behind this interest.
- **The Strategic Health Authority** found it difficult to define its role in health improvement. On the one hand it was expected to stand back and let local players lead the *Raising Health* bids. Performance management did not seem to be an appropriate mode of working at this point. On the other hand there was scope for the SHA to take on a developmental role. However, it was unclear how this contribution would fit with the support being offered by other bodies such as the HPA and HDA.
- **Local Strategic Partnerships.** Once some of the early questions about local authority roles in public health had been had been 'parked', if not resolved, the various organisations represented on the patch quickly formed into two large groups - clustered around the PCT/county council (Angelotti and Scarpiashire) and the unitary authority (Tosca) boundaries. The organisational entities that brought the players together were the Local Strategic Partnerships (LSPs). However, it became clear that these bodies did not have sufficient power, necessary leadership or legitimacy to organise resources around public health improvement. Too many competing interests were represented around the table. For the partnerships to take *Raising Health* forward it meant reducing these interests to lowest common denominators. We return to this theme in the following section on priorities.

- **Leadership within the LSPs.** Within the simulation, leadership for public health was not limited to public health professionals. Indeed local authority players (rightly or wrongly) saw these colleagues as bringing a predominantly medical model, which they mistrusted.
- Two distinct sets of leadership characteristics for public health were demonstrated in the simulation. One was sapiential – the knowledge of what interventions are known to be effective and how these would be likely to work in the local public health context. The second set of characteristics was skills in bringing together and balancing a complex set of interests and harnessing their collective energies. Both leadership elements were important but they did not reside in one individual or one professional group.
- **National bodies.** National bodies that had no local delivery arm, such as the Health Development Agency, found it difficult to contribute to vertical integration – they had no real way to link into area based initiatives, but were reliant on local awareness of their role and willingness to take up their tools and materials.
- **Regional bodies** tended to be overlooked by PCTs who tended to respond to their immediate community and partners rather than looking at the contribution that they could garner from vertical integration. It suggested that if regions are to make a contribution to smaller area initiatives they may need to take a leadership role in making the connections.
- **Primary care.** Primary care participants – GPs, school nurses and health visitors – demonstrated that they were in touch with some of the real health challenges and constraints affecting individuals and communities. However, they were seen primarily as individuals rather than representative of a constituency of interests. As a consequence, perhaps, their contributions were overlooked by more powerful interests.

4.2 Establishing priorities

- **Making sense of complexity.** Even though the simulation presented participants with a simplified set of public health pressures, both groups struggled to establish links and priorities. It proved far easier to focus on immediate and single-issue topics concerned with health protection or health improvements. Major issues (such as significant population growth and a new receiving centre for asylum seekers) that would have a significant impact on population health and health care were largely ignored. Although there was some discussion of these issues, they were ultimately by-passed. It can be inferred that the search for common denominators within the partnership meant that health care issues were overlooked.
- **Integrating frameworks.** Two integrating frameworks did find some resonance with the LSPs. The first was a focus on population groups such as children and young people or older people. Interestingly this did not really help the LSPs to identify shared priorities, although this way of structuring the issues did fit with the way social care services are organised. The second was a focus on settings – schools, workplaces, homes and hospitals. This started to be a useful filter for thinking about what interventions might be appropriate, but in later discussions it proved more effective as a tool for determining which bodies needed to be influenced (employers, school teachers, parents etc).

- **The ‘driving’ priorities.** Tosca PCT identified the new GMS contract as offering significant scope for influencing public health and chose asthma and respiratory diseases as their priority area. Although these priorities had been initiated by the ‘doctors’, the theme quickly attracted the support of the local authority, which saw several ways in which they could contribute to improved air quality.
- **Prioritisation helps.** Once priorities were finally agreed the *Raising Health* plans and bids took shape. Some comments were made about the unhelpfulness of a ‘bidding culture’, in that it encouraged a focus on how a limited pot of money would be used and diverted attention from how the full spectrum of mainstream resources could best be deployed. The bid for *Raising Health* pathfinder status may have been an artefact of the simulation design, but the funding had proved significant in engaging the interest of those bodies who did not see public health as part of their core role.

4.3 Interests and incentives

It was clear from the simulation that the recognition that better public health as a ‘good thing’ is not sufficient to mobilise collective energies. Public bodies and independent sector organisations alike may recognise the way that they affect health determinants, but to be prepared to take positive action towards health improvement they need to be able to see how better health affects their own interests.

- **Targets and performance incentives.** The different targets and performance management systems that the LSP players were subjected to had a real influence over the areas of work to which they gave priority. These systems put little emphasis on public health outcomes and generally provided LSPs and some of their constituent bodies with little incentive to prioritise public health. It could be argued that LSPs can choose their own priorities and measures. But faced with so many national ‘must dos’, LSPs felt they had little scope to establish a parallel set of local targets or to engage local people in such efforts.
- **Performance management and health.** Even within the health care sector it was felt that health related targets were of less significance than financial balance, waiting times or patient satisfaction.
- **Economic interests are powerful.** A small ‘break away’ group comprising the large employers – the university and acute hospitals – developed a parallel programme of work. They identified that investing in improving the health of employees would have a positive spin off for their core business, supporting improved productivity and lowering staff turnover. This alliance had effectively been successful because these ‘organisations’ had chosen to work together and shared common interests.
- **Acute hospitals** have an incentive to improve employee health through economic interest, but also recognised that they could contribute to improved health in the wider population. One of the dilemmas for PCTs seemed to be a desire to differentiate health from health care on the one hand and yet needing to harness the potentially valuable contribution of acute trusts on the other. Since this dilemma remained unresolved for both PCTs the acute trusts took matters into their own hands to ensure their influence was felt. Whilst PCTs do have an

explicit role and remit in improving the health of their populations, and generally recognise that this is something they cannot do on their own, the considerable emphasis that has been given to partnership working with local government has overshadowed the important contribution that other health care partners can make to *Raising Health*.

4.4 Freedoms and levers for change

The *Raising Health* pathfinder project asked bidders to identify what freedoms or additional powers would help improve the effectiveness of their efforts to improve public health.

- Local authority participants **identified a range of current levers that could be more effectively deployed or enforced** to improve public health. These included licensing laws, registration, traffic management, planning, bylaws, service provision and health and safety interventions. Health service participants were unaware of some of these levers and what they needed to do to influence their use.
- The freedoms that were identified were relatively modest. Many were theoretically possible within existing arrangements. The freedoms and powers included:
 - The ability to set local health improvement targets and engage local people in that effort.
 - Integrated performance management arrangements specifying common public health goals for both health and local government.
 - Freedoms to develop local procurement arrangements and opt out of national arrangements for the health system. This could be used to support local economic investment and could also foster partnerships between public bodies.
 - The ability to constrain or curtail the freedom of school governors on issues concerning health improvement elements of the curriculum.
 - Alignment of planning, budgeting and reporting cycles across health and local government.
 - A planning horizon that stretches beyond 1-3 years.
 - The ability to regulate public transport at a local level.
 - The ability to use section 106 agreements for the profits of land sales to come into LSP control.

4.5 Public engagement and individual empowerment

At the outset of the simulation participants had been given a clear steer about minister's thinking about public health and its position in the next phase of the Government's reform agenda from Paul Corrigan, John Reid's political advisor. That said, little consensus emerged about the most effective ways of engaging individuals and communities in the health agenda.

- **Differing philosophies.** We saw emerging three contrasting 'philosophies' of public and citizen empowerment – which we classified as *legislators*, *service providers* and *educators*.

- The *legislators* looked at opportunities for changing behaviour through the enforcement of current legislation and use of current powers. This included for example, banning smoking in public places and even the call for a new Clean Air Act.
- The *service providers*' approach to supporting improved health was through providing services such as smoking cessation, counselling and access to gyms which individuals could then choose to take up (or not).
- The *educators*' approach was based on the assumption that improving awareness of health determinants from an early age – within schools and engaging parental interest through their children - would lead people to take steps to improve their health.

Each of these parties was able to cite evidence of the effectiveness of their approach. What was less clear was their comparative effects and sustainability.

- **Community disengagement.** One of the blocks to public and citizen empowerment in the simulation was the perceived risk that actions taken by public bodies could have the opposite effect to that which was intended. Banning smoking in public places for example was discussed but rejected, as it was felt it could lead to a backlash or trigger further black market activity amongst smokers.
- **Approaches to empowerment .** Whilst there was considerable talk about empowerment and engagement as 'a good thing', participants found it difficult to identify what measures or incentives would be genuinely effective in achieving that end. Whilst paternalistic approaches could be easily identified and potentially easily implemented, some participants recognised they were falling into the familiar track of 'doing to' and potentially even 'doing to badly'.

5. Challenges to Raising Health: some conclusions and solutions

The simulation clarified some of the challenges to *Raising Health* and barriers to action that need to be addressed in the future. These are summarised in this section of the report. Section 6 outlines some options for tackling them.

5.1 The delivery platform

It is clear that, amongst the key stakeholders involved in public health, there is **no accepted or comprehensive delivery platform** for improving public health. By delivery platform we mean:

- Clear but also shared responsibilities and accountabilities for delivering improved health outcomes.
- A framework for establishing priorities.
- Performance management system(s) to provide incentives for delivering sustainable public health outcomes.
- Mechanisms that encourage horizontal integration at different levels (whether within neighbourhoods, municipal areas, regions or nationally) and vertical integration of effort between those levels.

Whilst it is clear that such a delivery platform is needed it is far from clear whether the appropriate level for this is within natural communities, neighbourhoods, wards, PCTs, SHAs, regions or even nationally. All levels have a potential contribution to make, but there is insufficient clarity about who should be initiating what, how they should relate to each other and what needs to happen to link these efforts together horizontally and vertically. Although the simulation brief was to find ways of tackling this issue, no clear solutions emerged.

5.2 Responsibilities and accountabilities

- **Contributions to improved public health are inevitably complex** because of the breadth of health determinants. The asset mapping exercise demonstrated that **some bodies remain unclear of their role in public health improvement**. Even where individual responsibilities and accountabilities were clear there was no shared understanding of how this related to the role of other players operating at the same geographical level or at other levels in the system. Appendix 3 summarises the results of the mapping exercise although should not be seen as a definitive picture of public health roles. Clear responsibilities and accountabilities at all levels would also help improve integration of effort horizontally and vertically.
- There is agreement that health improvement needs the individual and collective action of several bodies. A key question is who leads and coordinates that effort, in what capacity and

with what legitimacy. Equally, performance management systems need to reinforce those individual and collective responsibilities for delivery.

- **Co-terminosity and unitary local authority structures** have long been recognised as a way of oiling the wheels of health and social service integration and the same applies to public health improvement efforts. This was borne out in the simulation.
- Whilst **local authorities** acknowledge that they have a contribution to make to improved public health there it is not evident that this objective is central to their core work either in terms of policy or action.
- **Deeply ingrained stereotypes** about the interests in and contributions that can be made to public health exist across health and local government and within the health sector itself. These include both the conceptual model of health (medical vs. social) and predominant interests. These bring unhelpful baggage to the partnership table and need to be challenged. At worst, this can lead to a depiction of public health good and health service provision bad, with acute hospital care being seen as the worst possible manifestation of the latter.

5.3 Prioritisation frameworks

- There have been historic attempts to provide frameworks for public health improvement by successive governments – *Our Nation's Health* and *Our Healthier Nation* are two notable examples. Both struggled to find an appropriate integration and prioritisation framework on which to hang the policy and inevitably ended up with a mix of what's, where's and who's. There was some acknowledgement of these frameworks within the simulation but ultimately they did not prove helpful in prioritising local issues. This suggests that a fresh approach may be needed.
- The partner organisations within LSPs bring competing agendas to the table, and LSPs have insufficient tools and techniques to make sense of the range of public health pressures and select those that are either of greatest importance or where there is most scope to galvanise local action.
- There is either a lack of knowledge of or capacity for understanding how different health issues can be linked together, in order to develop an integrated framework for action. There are some current examples within national service frameworks, for example smoking cessation schemes prioritising lower socio-economic groups are intended to address coronary heart disease, cancer and inequalities targets. Encouraging local systems to make these types of linkages, identifying targets across organisations, could provide a basis for prioritisation of public health objectives.

5.4 Performance management systems

Although the government recognises that public health needs an integrated response across a range of public and private bodies, performance management systems currently do little either to prioritise public health improvement or encourage joint action in addressing those goals.

- CHAI (now known as the 'Health Commission') and the Audit Commission have signalled that they are working on a common tool to assess progress against health inequalities, which is a step in the right direction. It is unclear exactly how this will function and how much legitimacy this will have within local government. If local authorities' contribution to health remains a discretionary function, there will continue to be a risk that public health will remain an NHS preoccupation. Changing the content of Public Service Agreements is a natural first step to giving local authorities a clearer role and responsibilities in improving public health.
- Most performance management systems take a short-term view of targets and improvements. Many public health improvements take time to establish and deliver sustainable results.

5.5 Public health leadership and capacity for delivery

The simulation highlighted to leadership for health improvement does not reside in one professional group.

- Traditionally, directors of public health have been seen as one of the figureheads for mobilising action. With the establishment of primary care trusts, public health capacity has been diffused and distracted. By diffused we mean distributed thinly across a larger number of organisations than hitherto, although networking arrangements have been put in place to try to compensate for this dispersal.
- The requirement for directors of public health to take a seat on PCT boards and professional executive committees has meant that a significant part of public health professionals' capacity is now taken up with these and other corporate functions. This is a legitimate place from which to exercise sapiential leadership – informing PCT decisions and providing professional advice on public health challenges and priorities and effective policy and interventions. However, undertaking this role has distracted public health professionals from contributing to public health delivery programmes.
- Public health delivery requires two elements. Firstly the change management skills to bring together disparate resources and encourage their joint focus on achieving improved public health outcomes. Part of this work will involve commissioning particular programmes of work for public health improvement. Secondly, there are specific skills that need to be deployed to support public and citizen engagement in health. These skills are wide ranging including contributions from epidemiology, statistics, education, community development, health promotion and others. The difficulty at present, highlighted in the simulation, is that these two elements tend to be conflated. This can lead to the inevitable argument that there is not sufficient capacity to tackle the issues.
- However, not all elements of public health delivery need rest with specialist public health professionals. On the one hand there is scope for generic change management skills to be applied to public health issues. PCT chief executives and PEC chairs could for example be required to take on a health leadership role for example. On the other there are opportunities for more lateral thinking about how alternative sources of capacity for delivery can be mobilised. Others with the potential to play key roles include school nurses, health visitors, school governors and teachers.

5.6 The evidence base

- Lack of evidence about public health determinants does not appear to present a significant barrier to action. There has also been considerable improvement in the dissemination of knowledge-tools such as the National Electronic Library and the CHI good practice database were identified as helpful resources. The Health Development Agency is also tasked with providing clear guidelines on what works to prevent ill health and cut inequalities. There is also a wealth of evidence about which interventions are effective. In some cases, there is too much evidence, but no clear means of prioritising it. Some of this information is well known, but is often not supported by the practical tools to address it.
- What is less clear is the comparative evidence of which individual interventions work better than others and the circumstances that contribute to that effectiveness. Such intelligence could help inform local investment decisions.

5.7 Levers for change

- There are many levers that can be used to target health improvements at population and individual levels. Not all of these are well used or fully explored within individual organisations are appreciated by their partners.
- There would be merit in greater sharing of how different powers and levers have been applied to address public health issues and of the impacts of those initiatives (both intended and unintended). Such work would appear to fall between the responsibilities of the Health Development and Health Protection Agencies.

6. Options for a Public Health Delivery Platform

In this section we set out some options for addressing the challenges and barriers outlined above. The proposals are designed to establish an effective delivery platform for *Raising Health*.

6.1 Responsibility and accountability

In the previous section we emphasised that public health responsibilities are complex but also somewhat vague at present. There is a need for a greater clarity about individual responsibilities and where accountability for bringing together these efforts should lie. The obvious candidates for this horizontal co-ordination and leadership role are:

- Local authorities
- PCTs
- SHAs
- Government offices
- Regional arms of the Health Protection Agency
- Health development agency
- Local strategic partnerships

The first five have some legal status, but LSPs do not. In the table below we set out an analysis of the strengths and weaknesses of each party as a basis for galvanising public health delivery.

Organisation	Strengths	Weaknesses
1. Local Authorities	<p>Responsible for a number of areas (housing, transport, environment) known to be significant determinants of health</p> <p>Ability to influence education providers offers the opportunity to influence children and families</p> <p>Democratic bodies with powers to scrutinise health service bodies</p> <p>Traditional environmental health function</p>	<p>Public health not currently part of PSAs or CPA frameworks</p> <p>Ability to provide public health focus in schools is diluted by role and powers of school governors</p> <p>Dual layers of local government present coordination difficulties outside unitary authorities</p> <p>Changes in elected members do present a challenge to long term investments</p>

Organisation	Strengths	Weaknesses
		Priority given to public health issues variable
2. PCTs	<p>Small enough to get a grip on local issues and variations between areas and population groups.</p> <p>Health improvement has been a core role, with specific targets.</p> <p>Have technical expertise in the form of public health and other health care professionals.</p> <p>Networks can provide effective ways of providing specialist advice, but are not always working.</p>	<p>Some still too small and facing capacity problems in handling change management agenda</p> <p>Some lack legitimacy in influencing larger municipal bodies and other organisations that can influence health determinants</p> <p>Number of public health professionals in each extremely limited, so capacity for public health delivery may be limited.</p> <p>Perceived by partners as having an overly medical model</p>
3. Strategic Health Authorities	<p>Ability to read across several PCTs and establish relationships with statutory bodies larger than single PCTs.</p> <p>Have a relationship with the acute trusts, who themselves have the potential to make a significant impact on public health.</p>	<p>Few are currently organised around a public health remit – some do not have public health professionals within top team – although they have an upward reporting responsibility.</p> <p>No remit to performance manage local authorities.</p> <p>Direct relationships between health and local government now more typically handled at PCT level</p>
4. Government Offices	<p>Large enough to have capacity for analysis of health determinants</p> <p>Ability to provide horizontal integration with other government initiatives and levers within regional context</p> <p>Scope to link health with economic</p>	<p>May be too large to influence these determinants on the ground</p> <p>Regional agenda for this government still unclear</p> <p>There is a lack of clarity about their links to the NHS</p>

Organisation	Strengths	Weaknesses
	<p>development through links with regional development agencies</p> <p>Already health observatory presence at this level, undertaking surveillance and providing data</p>	
5. Health Protection Agency	<p>National body with regional delivery arm suggesting that it could provide a force for integration at both levels</p> <p>Formal health protection role that stretches beyond the NHS</p> <p>May be seen as less medically dominated than NHS bodies</p> <p>Potential to link across NHS, local authorities and government offices</p>	<p>A relatively new body that has a significant agenda in integrating its predecessor bodies</p> <p>Role not yet well understood.</p> <p>Currently a limited remit (although should the legislation go through, this will widen to include communicable disease control).</p>
6. Health Development Agency	<p>Wealth of expertise in understanding what public health interventions work</p> <p>Potential to link across NHS, local authorities and government offices</p>	<p>No delivery arm – primarily advisory</p> <p>Health promotion and development has a chequered history under successive governments so may not provide a stable platform for the future</p> <p>Powers are primarily advisory.</p>
7. Local Strategic Partnerships	<p>Potential to mobilise most of the statutory players that can contribute to or influence health outcomes</p> <p>Ability to coordinate and oversee work across a range of public health topics e.g. drugs, crime and disorder</p> <p>Provides a focus for horizontal integration at local level</p>	<p>Health is one of several competing interests</p> <p>LSPs are not uniform across the country</p> <p>No legal legitimacy to act e.g. to enter into contracts or to oversee pooled budgets</p> <p>Takes time to develop mature partnerships</p>

Organisation	Strengths	Weaknesses
		Who chairs and where the secretariat and management support is based may be contentious

It is clear from the table above that each of these bodies has up-sides and down-sides. A combination of regional leadership with locally coordinated action may be the optimum approach.

6.2 National level

Not everything can be left to local and regional level. Decisions are needed at national level about the relative importance and position of public health. Horizontal integration applies as much here as at local level. The clear candidate for this role is the Department of Health but there may be other options, including the Cabinet Office, ODPM or the Treasury. Major changes are taking place across Whitehall involving the significant downsizing of Departments and shift of functions. This has been true of the Department of Health for some time and recent review of agencies and special health authorities has added a further strand of uncertainty. If the Government are serious about improving public health there must be absolute clarity of responsibility for co-ordinating cross-departmental contributions to health improvement and an overview maintained of national public health programmes and of the opportunities presented by greater European integration. The latter function could sit outside the Department of Health but it does need formal identification, with clear cabinet level responsibility.

6.3 Regional leadership

At regional level the most appropriate body for leading public health priorities and their implementation would appear to be government offices. The regional public health observatories and regional development agencies also have a significant role in supporting employer efforts to improve health through workplace initiatives. The regional directorates of the Health Protection Agency should be actively engaged in this work.

Historically, regional public service tiers have had differing geographical boundaries but a helpful step in recent years has been their alignment. In summary, the building blocks are in place for effective horizontal integration of health improvement efforts at regional level.

At a sub-regional level, strategic health authorities need a performance development as well as performance management remit.

6.4 Local delivery

At local level, LSPs could be seen as the delivery arm but current conditions are not sufficient to make this a sustainable and watertight option. Local authorities need to have an explicit remit in contributing the health of local residents. However, the way that this is defined is crucial. Simply

giving local authorities a role in 'taking account of' health impacts in their wider work is unlikely to have real grip. Further clarification of the role of PCTs would also be needed.

Further measures that would help strengthen horizontal integration are considered in the remaining sections of the report.

6.5 Performance management

To provide incentives for horizontal and vertical integration and for concerted action by all bodies that can contribute to *Raising Health*, performance management systems need to be changed.

The following are needed:

- **A limited number of national long- term targets** and an expectation that local targets will be developed through a process of community engagement. For national targets there may need to be some flexibility about the rate at which progress can be made or targets set on the basis of current local baselines.
- These national public health targets could be specified for LSPs but the bodies accountable for meeting them should be local authorities and their respective PCTs. Together they should be responsible for developing **a broad-based *Raising Health* action plan** for addressing the national targets and working on an agreed set of locally specific priorities. The plans would clarify the respective contributions and responsibilities for meeting the targets by health service bodies, by local government and other significant parties locally and regionally. These would be more broadly based than the predecessor Health Improvement Plans and less focused on health services. The plans would address how current levers and powers would be deployed to achieve health objectives. They would also consider what regional and national support should be brought into play.
- These national targets need to assess both overall health improvement and the extent to which inequalities between different sections of the community have been reduced.
- Underpinning these targets would be:
 - Data sharing protocols, particularly from health to other agencies, and capacity within the system for collecting and sharing information
 - Appropriate data collection mechanisms within primary care that are compatible with GP computer and coding systems
 - Measurement systems that reflect the time it takes for mature partnerships to deliver. Year 1: measure change in the way agencies work; year 2: measure changes in health behaviours; year 5: measure changes in health outcomes.
 - Common public health benchmarks against which organisations and localities can compare their performance.
- To support the above, what is needed is **a common performance management system**, reviewed by a single regulatory body, that holds local government and its respective health care partners to account for improvements to public health. This could build on the work already being undertaken by the Health Commission and the Audit Commission.

- Analysis of programme budgets – the way that total resources are allocated across particular population groups for health issues could also focus minds about the extent to which health inequalities are really being addressed. This could be inter-sectoral, with pooled resources.
- Local partnerships – whether LSPs or alternative arrangements – need to be **given stability and time to deliver**. There is a history of goalposts being changed around initiatives designed to deliver health improvements. Health action zones, for example, ceased to exist at the point at which some were entering a mature phase of partnership and capacity. This suggests the need for a developmental and supportive performance management system rather than one that is punitive or leads to rapid turnover of key leaders.

6.6 Leadership, management and delivery

There is an increasing need to **differentiate public health advice from the delivery of public health programmes**.

- **Public health advice**. This needs to be available to individuals, organisations and to their collective efforts for improving public health outcomes. Advice could come from a number of organisations and levels, including the HPA, the HDA, PCTs, and directors of public health. The critical mass of public expertise provided in the previous health authority public health departments has been lost with the transfer of public health resources to PCTs. This does not necessarily imply that a massive expansion in the number of public health doctors is needed, but clear advice and methods of dissemination are.
- **PCTs should retain a corporate public health function** at board and executive level to provide professional advice on policies and priorities. An equivalent resource will be needed within local authorities in recognition of their wider powers. This could be, and in some cases already is, met by a single joint appointment and joint team. This makes sense where the PCT, local authority and LSP are coterminous.
- **Responsibility for the commissioning of public health programmes** for a population may or may not reside in a different place to public health advice. In some cases this work may best be handled at the regional tier. Greater financial input to the commissioning process might enable the scope for pooled resources to be exploited effectively.
- There needs to be investment in the **change management aspects of public health leadership**. This could be both through supporting the skills development of public health professionals and by encouraging lateral movement of general managers with change management and inter-organisation development expertise to work in public health contexts.
- The delivery of programmes in line with the ‘Fully Engaged Scenario’ outlined in the Wanless report requires a wide range of contributors, way beyond the traditional remit of public health and health promotion professionals. Indeed, at a very local level some of the community development workers employed by local authorities and independent sector organisations might provide more appropriate leaders than traditional public health models.
- There is scope for **development of new roles and creative approaches to providing public health skills**. There are already examples on which to build – community wardens and

health action workers to name but two. The GP contract offers the potential to increase the role of GPs in promoting health improvement. Further work is needed to assess the effectiveness and sustainability of current initiatives, explore potential future models and link these findings to education, training and development measures. Workforce development confederations could play a helpful role in taking forward this work, as could the NHSU.

- To inform LSP plans for improving health, there is a case for improved data sharing and investment in analytical capacity. Some areas have already invested in such initiatives. The resources within regional public health observatories are also hugely significant. Now that these bodies are fully established their role needs to evolve to provide tailored analyses and potentially commissioned analyses for local areas and to support local skills in combining regional data sets with local details.
- Relationships with academics and research need to be strengthened.

6.7 Levers and incentives for raising health

Existing levers for change

- Some of the useful freedoms highlighted in the simulation have already been noted. However, by far the strongest message is that the current levers and incentives are not as fully used as they could be.
- Funding schemes for area-based initiatives tend to be tightly prescribed both in terms of geography and how the schemes operate. Greater flexibility to interpret local circumstances and address capacity issues could help trigger innovative solutions to local difficulties.
- PCTs need to ensure that the new GMS contract is used to encourage GPs and practices in addressing public health issues. But this would need to be balanced with approaches that support empowerment and self-determination that are seen as crucial to sustainable behavioural change.
- Better linkages between current initiatives targeting health inequalities could improve their collective impact. For example the transition between Sure Start, Children's Fund, Extended Schools and Connexions schemes could be reoriented at national level to enable smoother implementation locally. This too could be encouraged through performance management processes.

Engaging individuals and communities

- The need to **engage individuals and local communities in the public health agenda**, in terms of their contribution to target setting and in terms of responsibility for their own health may be accepted. Making this work in practice however, is the real challenge. Some measures used to encourage self-determination can backfire and be seen as coercion. Some of the levers that could be used to make a difference include:
 - PCT and local authority public involvement and citizen engagement work that is better integrated

- Popularising the notion of individual health plans (along the lines of personal development plans)
- Increasing the public health element of training and development of NHS staff working with individuals

Health and economic development

- A stronger national recognition of the complex links between health and economic development would help in engaging non-NHS bodies in the public health agenda.
- The economic power of public sector organisations could be more effectively harnessed to support local development. The effectiveness and impact of current NHS rules requiring centralised procurement need careful analysis and comparison to alternative approaches such as shared local procurement schemes between health and other public bodies. At a conceptual level it could be argued that freedoms to procure locally for a range of products could stimulate local partnerships between statutory services, and might also help to forge relationships within the LSP.
- Public sector bodies could be encouraged to take a lateral view of procurement for estates developments by considering not only price but other factors that may have a beneficial effect on people's health
- Regional development agencies should be given a clear brief to coordinate support to public and private employers in providing healthy employment. This could include brokerage between the NHS and private companies in provision of occupational health, re-orienting regulation and inspection systems to give a stronger health focus, or providing grants or transitional loans to help firms introduce new measures that will delivery economic benefits through a healthy workforce. At national level, tax or insurance incentives may also have a role to play.
- Economic and social developments that are already anticipated, such as areas of targeted population growth, where new airports or other infrastructure facilities are planned and places that are expected to house prisons or asylum seekers need special long-term attention. Firstly, health impact assessments need to inform the overall master plan for such developments. Secondly, health care facilities need to be properly planned from the outset. Any increase in national focus on public health should not be at the expense of ongoing concerns to improve health care.

7. Conclusions

The *Raising Health* project has highlighted two clear messages:

There must be a clear, accountable and visible delivery platform for taking forward the public health agenda

The default option for public health initiatives to be led by NHS bodies – most typically PCTs – is not in itself sufficient. There are places where PCTs have demonstrated excellent public health leadership and where partnerships and relationships with local authorities and other public services have delivered improvements in health. However, public health needs a broader base of accountability and delivery at local, regional and national levels and processes to safeguard horizontal and vertical integration. This should be supported by a framework for establishing priorities and a simple performance management system.

Getting the delivery platform right need not and should not involve massive structural reform – at best this might detract from the real task of improving public health – at worst it could deflect resources and actually weaken existing delivery mechanisms. The building blocks are there but need joining up and strengthening.

Existing incentives and change levers can be used more imaginatively and more effectively

The need for this is even more crucial if the ‘fully engaged’ scenario is to be a reality. New relationships between individuals, communities and health require radically different responses from the state and public services.

These incentives and levers exist as much in the health care system as in local government. But both sets of organisations need far stronger incentives to focus on outcomes than on service inputs and processes. These need to be reinforced through an integrated performance management system but there also needs to be greater sharing of how current powers can be deployed or enforced to improve public health.

The role of the health care sector in improving health also needs a mention. Whilst it is clear that better health is not the preserve of the NHS this need not mean that the role of the health care sector in contributing to positive health in addition to the diagnostic and curative role must not be overlooked. Acute and mental health trusts have a real part to play in improving the health of their employees, their patients and their local community.

Finally, with a public service system still reeling from a tight culture of control and delivery, the challenges of changing tack – of letting go and supporting others to deliver improvements – cannot be underestimated. There is a real need for investment in organisation, inter-organisation and individual development to support public services and public health in making these shifts.

Appendix 1: Definition of ‘Public Health’

The Faculty of Public Health defines public health as: ‘*The science and art of preventing disease, prolonging life and promoting health through organised efforts of society*’.³

It recognises the public health approach as:

- Emphasising the collective responsibility for improvement in health and prevention of disease;
- Recognising the key role of the state, linked to a concern for the underlying socio-economic and wider determinants of health, as well as disease;
- Multidisciplinary, incorporating quantitative as well as qualitative methods
- Emphasising partnerships with all those who contribute to the health of the population.

Public health practice is commonly defined under three headings:

1) Health Protection and Prevention

- Disease and injury prevention
- Communicable disease control
- Environmental health hazards
- Emergency planning

2) Health and Social Care

- Quality
- Clinical effectiveness
- Efficiency
- Service planning
- Audit and evaluation

³ Public health professionals are employed throughout the NHS – in trusts, PCTs, health authorities and boards - in government departments and in academic and research institutions. In other countries the organisational settings for the practice of public health vary according to local circumstances. Public health medicine is the branch of medicine concerned with improving the health of the population rather than treating the diseases of individual patients. Public health doctors work with other professional groups to monitor the health status of the community, identify health needs, develop programmes to reduce risk and screen for early disease, control communicable disease, foster policies which promote health, plan and evaluate the provision of health care, and manage and implement change.

- Clinical governance

3) Health Improvement

- Employment
- Housing
- Family/community
- Education
- Inequalities/exclusion
- Lifestyles

Appendix 2: The *Raising Health* Issues

Participants were provided with details of the following key public health issues on their patch:

Health Service Provision

- Introduction of new primary care access targets
- Infection control teams identified increased incidences of MRSA
- Local women campaign for breast screening age to be reduced to 40
- Inequalities in uptake of CHD rehabilitation
- Inequalities in diagnosis of cataracts and diabetes
- Significant population growth projected over the next decade
- Open prison likely to be established in the Northern part of Scarpiashire
- Accommodation centre for asylum seekers proposed

Health Protection

- Increase in children involved in traffic accidents
- Air pollution identified as a contributory factor to increased childhood asthma
- High levels of radon affecting local housing estate
- Socially isolated older people
- Health & employment concerns relating to the spread of Avian Flu
- Increased incidence of TB
- Proposed runway expansion at Tosca City Airport

Health Improvement

- Rising levels of children diagnosed with Type 2 diabetes
- Variable dental health
- Incidence of teenage pregnancy and self harm rising in rural communities
- Proposals to improve two housing estates have met local opposition
- Drug Action Team has identified new use of 'snax' amongst the student and gay population
- Increase in diagnoses of chlamydia and HIV / AIDS
- Excluded children are missing out on PHSE
- Increased admissions and deaths amongst older people due to hypothermia

- Shared smoking cessation service has failed to meet government-set targets
- Poor access to sports facilities
- Closure of the financial services call centre in Verdi

Appendix 3: Asset Mapping

Participants were grouped according to their organisation (e.g. PCT, SHA etc.) and asked to identify:

- To whom their organisation is accountable;
- The responsibilities of their organisation;
- Assets available to the organisation that could be used to improve public health;
- Powers and levers the organisation could use to improve public health.

The following table briefly describes accountabilities, responsibilities, assets, powers and levers that participants identified:

	Accountabilities	Responsibilities	Assets	Powers & levers
Department of Health	<ul style="list-style-type: none"> ▪ Parliament ▪ Ministers ▪ EU 	<ul style="list-style-type: none"> ▪ Target setting and monitoring 	<ul style="list-style-type: none"> ▪ Workforce – skills, knowledge 	<ul style="list-style-type: none"> ▪ Influencing legislation ▪ Setting regulations & policy ▪ Resource allocations/ incentivisation ▪ Regulatory mechanisms ▪ Legislation ▪ Regulation ▪ Financial resources allocated / incentivisation ▪ Policy formation ▪ Strategic leadership of NHS ▪ Influence through broader range of commissioned bodies ▪ Public credibility depends on the issue – how communicated / to whom

	Accountabilities	Responsibilities	Assets	Powers & levers
<ul style="list-style-type: none"> ▪ HPA 	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪ Identify health protection issues, such as infectious chemicals or other environmental hazards. ▪ Provide independent information and advice to the public. ▪ May provide an immediate response e.g. for a chemical release. ▪ Develop an evidence base on health protection issues. ▪ Provide specialist services, expertise and support on a regional basis. 	<ul style="list-style-type: none"> ▪ Teams of specialists at local regional and national levels. ▪ Specialist facilities, e.g. laboratories and manufacturing. ▪ The only provider of some specialist services, skill areas and systems. ▪ Sufficient critical mass to provide: ▪ An integrated and consistent response to health protection issues; ▪ Career development of staff; ▪ Specialisations; ▪ Responses at a local and national level. ▪ Able to provide training / education 	<ul style="list-style-type: none"> ▪ Information provided is independent of the government and Health Service. ▪ The HPA is able to influence a wide range of organisations although it has few statutory powers ▪ Subject matter is of public interest.
<ul style="list-style-type: none"> ▪ HDA 	<ul style="list-style-type: none"> ▪ Board ▪ DoH ▪ Potential to work to wider accountability with public health workforce 	<ul style="list-style-type: none"> ▪ To provide high quality, practitioner focused information to support the development of health services. 	<p>Evidence based – H.I.A.</p> <ul style="list-style-type: none"> ▪ Health improvement ‘what works’ ▪ Examples of good practice ▪ In time, will develop business and economic case <p>Developing skills and knowledge in public health</p> <ul style="list-style-type: none"> ▪ Competitive development ▪ Workforce support in relation to abuse <p>Understand / advice on systems</p> <ul style="list-style-type: none"> ▪ Partnerships – advice on LSPs ▪ Scrutiny (OSC) 	<ul style="list-style-type: none"> ▪ Ability to influence others, rooted in the HDA's authority, credibility and brand. ▪ Regional (G.O.R) partnerships ▪ Local partnerships – PCTs, LAs, SHA (perf mgt) LDPS, OSCs, ▪ Researching future national policy to support the work of CHAI and the Audit Commission. ▪ Partnership with national professional organisations – FPH, CPHVA, etc

	Accountabilities	Responsibilities	Assets	Powers & levers
			<p>Staff to support systems</p> <ul style="list-style-type: none"> ▪ PH networks – PCTs ▪ GOR (regional staff) 1 per GOR ▪ SHAs - 1/2 posts in each SHA by the end of 2004 	
▪ SHAs	<ul style="list-style-type: none"> ▪ Department of Health 	<ul style="list-style-type: none"> ▪ Some health protection ▪ Performance management of local health economies. ▪ Support the development of local health economies, including through capacity building. 	<ul style="list-style-type: none"> ▪ Money ▪ Information – CHA / CHAI ▪ Information PHO/ CAREG etc.. ▪ Networks across GO and across region ▪ Credibility/status 	<ul style="list-style-type: none"> ▪ Culture: performance as given licence to innovate – performance data ▪ Personal relationships and networks ▪ ‘Pattern of incentives’ good cop bad cop subversion ▪ Approving structures ▪ Supporting bids ▪ Everything can be converted level 2
▪ PCTs	<ul style="list-style-type: none"> ▪ Secretary of State – through SHA ▪ Strategic health authority ▪ Local authority, through the Overview & Scrutiny Committee ▪ Population – through, amongst other mechanisms, the Patients Forum ▪ Professional accountabilities 	<ul style="list-style-type: none"> ▪ Statutory responsibilities ▪ delivering effective & good quality health care ▪ Commissioning secondary care services ▪ Commissioning primary care services ▪ range of services for our population ▪ Improve health of local population ▪ Reducing inequalities in health ▪ Meeting targets 	<ul style="list-style-type: none"> ▪ Facilities and buildings ▪ Staff ▪ Partners / population ▪ City council – elected members ▪ Hospitals ▪ Staff ▪ 	<ul style="list-style-type: none"> ▪ People ▪ Commissioning role: controls budgets for all local health organisations ▪ Procurement role: ability to act as corporate citizens ▪ Power to set priorities ▪ Partnership arrangements including: shared services e.g. Sure Start; strategic influence e.g. LSP and Community Plans ▪ Potential to influence strategic issues across the region

	Accountabilities	Responsibilities	Assets	Powers & levers
<ul style="list-style-type: none"> ▪ City Council 	<ul style="list-style-type: none"> ▪ Electorate (local) ▪ Government departments providing funds (ODPM, DoH, DEFRA, etc.) ▪ Cabinet / executive ▪ Audit Commission (comprehensive performance assessments, best value review & annual performance plan) 	<p>Services</p> <ul style="list-style-type: none"> ▪ Housing – landlord, enabler ▪ Environmental health ▪ Trading standards ▪ Education ▪ Social services / social care ▪ Planning ▪ Transport (enabler) ▪ Leisure ▪ Community development ▪ Regeneration ▪ Economic development ▪ Youth services ▪ Waste collection and disposal ▪ Community safety and security (role) <p>Functions</p> <ul style="list-style-type: none"> ▪ Representing local people – community leadership ▪ Land owner ▪ Procurer ▪ Employer 	<ul style="list-style-type: none"> ▪ Local identity ▪ Democratic legitimacy ▪ Local knowledge and networks ▪ Land, capital, buildings, ▪ Powers, (legal, enabling, well-being) ▪ Human resources ▪ Wide range of skills, knowledge, professional expertise ▪ Income generation capacity (e.g. regeneration, EU funds) ▪ Enforcement powers (ref. Community safety – antisocial behaviour orders ASBOs) 	<ul style="list-style-type: none"> ▪ Political influence (local, regional, national, and potentially European) ▪ Local influence (e.g. local communities and other agencies) ▪ Degree of local flexibility to initialise resources ▪ Years of knowledge / experience ▪ Ability to use £ to lever in match funding ▪ Evolving partnerships (especially voluntary sector)
<ul style="list-style-type: none"> ▪ County Council 	<ul style="list-style-type: none"> ▪ Local electorate ▪ ODPM (DoH, DfES, DET, DTI, etc.) ▪ Government office regional ▪ RDA developing regional assembly ▪ EC – funding CESRF 	<ul style="list-style-type: none"> ▪ Statutory – housing, social care, education, crime and disorder, economic development, cultural services, maintaining roads, air quality, some transport (not rail / air), environmental services, parks and open spaces ▪ Adult learning ▪ Civic leadership (consultation and 	<ul style="list-style-type: none"> ▪ Local land owner (housing conditions) ▪ Enforcement agency for environment ▪ Responsibility for education (3 – 16 yrs) means can target children for health education ▪ Role in determining air quality / noise pollution ▪ Opportunities for physical activity e.g. parks pedestrian 	<ul style="list-style-type: none"> ▪ LGA 2000 – well being planning authority, trading standard, licensing landlord, register of other landlords, Education Act, some environmental enforcement powers, traffic management / cameras / parking enforcement ▪ ASBOs, care orders, etc.

	Accountabilities	Responsibilities	Assets	Powers & levers
		<p>engagement) – collective decision making</p> <ul style="list-style-type: none"> ▪ LSP and ensuring the services we don't control e.g. utilities, health, deliver for the benefit of real people ▪ Health scrutiny 	<p>walkways, cycling routes, leisure centres</p> <ul style="list-style-type: none"> ▪ Procurement powers ▪ Support to local SMEs could include public health elements ▪ Direct employer 	<ul style="list-style-type: none"> ▪ Levers: funding streams, allocation e.g. Neighbourhood renewal, Voluntary sector, S.106 (planning gain) ▪ Statutory plans e.g. crime and disorder, local transport plans, community plan priorities ▪ District council CPA/BVPL – to improve health scrutiny? ▪ Local Government Act ▪ LSP
<ul style="list-style-type: none"> ▪ University 	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪ As employer to staff and to students ▪ For sustainable development and management of estate and facilities ▪ Training and education of local population and future health workers ▪ Continuing professional development ▪ To work in partnership with other stakeholders for local health ▪ To build the knowledge base for effective policy and implementation ▪ Building capacity to identify and solve problems 	<ul style="list-style-type: none"> ▪ Buildings and land ▪ Skills and knowledge ▪ Reputation and influence ▪ Powerful constituency ▪ Alumni 	<ul style="list-style-type: none"> ▪ Influence and advocacy ▪ Communication ▪ 'Honest brokerage' and facilitation ▪ Lifelong learning ▪ Develop new ways of building skills and knowledge ▪ AUT / NUS VCS