

NEED TO KNOW

Review Number Two



Local Government
Knowledge Navigator

What Local Government Needs to Know about Public Health

A Local Government Knowledge Navigator
Evidence Review

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THE NEED TO KNOW SERIES

Jane South, David J Hunter and Mark Gamsu have prepared this review of evidence on public health that is relevant to local government. It is the second in the 'Need to Know' series, commissioned by the Local Government Knowledge Navigator.

'Need to Know' reports are summaries of available research-derived knowledge and evidence relevant to topics that have been identified to the Knowledge Navigator as priorities by local government. They:

- Highlight key areas of relevant knowledge
- Signpost where the evidence can be accessed in more detail, and

- Identify where research investment has potential to meet any gaps identified in that knowledge and evidence base.

We invite and welcome feedback on this review, and suggestions for future topics for the Need to Know series: please email admin@ukrcs.co.uk with your views and suggestions.

THE LOCAL GOVERNMENT KNOWLEDGE NAVIGATOR

The Local Government Knowledge Navigator is a two-year initiative funded by the Economic and Social Research Council (ESRC), and steered by ESRC, Local Government Association and Society of Local Authority Chief Executives. It aims to help local government make better use of existing national

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Local Government Knowledge Navigator

CONTENTS

Summary

		x
1	Introduction	x
2	Governance for Health	x
3	Planning for Local Public Health	x
4	Evidence and Public Health	x
5	Concluding Remarks	x
6	Further information and references/bibliography	x

SUMMARY

This review of existing research on local government and public health focuses on the leadership role of local government in developing local public health systems that are capable of addressing the wider determinants of health.

It maps available evidence and highlights some options for local decision makers. Major themes include:

- Local government is the leading local democratic institution and as such is responsible for shaping the way that citizens are involved in their own wellbeing, can improve wellbeing in their communities, and hold local health and wellbeing services to account.
- As part of local government's place-shaping role, health needs to be brought into local policies and strategies, such as spatial planning or transport.
- The scope for action is wide and the review has highlighted a range of approaches across different levels and sectors of local government activity. While an evidence base exists for some approaches, for newer ones the local government role has yet to be fully realised and evaluated.
- Public health is best viewed as a system comprising interrelated networks and structures with many organisations and people having a part to play. Partnership working is necessary to develop coordinated action on public health and there exists a sizeable evidence base on the factors which make for success and failure; however, the evidence on outcomes is weak.
- Prior to the return of public health to local government, research suggests that it was hard to maintain a focus on the social determinants of health; this was in part a consequence of tensions between national and local priorities pushing and pulling in different directions but also a consequence of the NHS's focus on acute hospital care and treating individuals.
- There is some evidence on the role of health scrutiny and on citizen participation in area based initiatives, but generally there is a lack of research on local democracy and public health, including the health role of mayors and elected members.
- Evidence needs to feed into local government planning and decision making, but what is understood by evidence and the different types of evidence are hotly debated issues in public health. The review provides a guide to some of the major sources of evidence and highlights research gaps.
- International research can provide some useful pointers to alternative models of local government action.

1. INTRODUCTION

For many in local government the return of responsibility for public health is both welcome and not before time; indeed, the public health function can be traced back to the origins of local government in the 19th Century.

However, over the past 40 years, not only have local authorities changed considerably but the public health function has had to adapt to its location in a National Health Service dominated by a medicalised view of health with its focus on ill-health and disease.

Many elected members and senior officers have recognised that it is particularly important that local authorities work with their new public teams to re-define what an effective public health function is within a local authority context. Such a context includes a local council's political traditions, its wide range of services that address the social determinants of health, its democratic connections with citizens, and its role as a local leader - responsible for setting the tone and culture in an area.

Although the transfer of public health has been largely welcomed, the current environment is particularly tough and challenging. Local authorities are experiencing huge and deep cuts in their financial support from central government which affects the services that some of their most vulnerable citizens rely on. At the same time, these same people are particularly affected by the impact of the economic crisis and government policy, with increases in unemployment and reductions in welfare support. All of which has a negative impact on their health and wellbeing, both physical and mental.

These changes and pressures mean that local authorities will need to be very clear about two issues: first, what should the balance be between their public health activities - should they focus on general population wellbeing or on tackling health inequalities or on improving the health of individuals? And, second, what are the most effective actions and structures that will enable them to achieve public health outcomes? While the former question is primarily an issue for local determination, the latter requires consideration of the evidence base that might support different actions that local authorities might take to improve the health of local populations. This rapid review provides a picture of what research is available, identifies major themes and discusses how these themes can inform the role of local government in public health and the scope for intervention across an area.

The aim of the review was to map and summarise social science research on the role of local government in public health. There were three review objectives:

- To provide an overview of research on governance for health at a local government level.
- To identify research-based options that may allow local government to effect improvements in the health of their communities.
- To provide a brief critical commentary on the various types of evidence that can be used to inform local government action on public health.

The review draws principally on UK research and European reviews commenting on local government and health. Research from other countries and web-based resources are highlighted where relevant. Further details on review methods can be found in [Annex A](#).

This report provides a guide to what social science research says about the local government role in public health. [Section 2](#) looks at how local government responsibilities fit within a broader social determinants approach to health; [Section 3](#) signposts some alternative approaches; and [Section 4](#) comments on evidence debates and on-going research.

Local policy makers and practitioners need credible and robust sources of information in developing the public health role of local government. In summarising existing knowledge, this report draws out relevant themes and common issues which may help shape thinking in local government about how to deal with some of the 'wicked issues' associated with improving the public's health. Research reviewed here can be used to inform frameworks for action based on a social determinants approach to health and wellbeing, adapted as appropriate to particular local contexts. There are a number of places in the report where the implications for practice are discussed and options highlighted. Furthermore, in gathering existing knowledge on the topic, the report serves as a source document that those with an interest in local government research can use to navigate a rich and varied body of work.

2. GOVERNANCE FOR HEALTH - WHAT DOES RESEARCH SAY ABOUT THE LOCAL GOVERNMENT ROLE?

This section provides an overview of social science research on local government and public health relevant to England. It draws on primary research conducted in the UK and evidence reviews that summarise research and/or learning from practice.

The focus is on understanding the local government role in public health and highlighting sources of evidence that can be used to inform local wellbeing strategies. It moves through different levels of governance from 'whole-of-society, whole-of-government' approaches to local democracy. Public health involves multiple sectors, organisations and stakeholders, so we use the term 'public health system' to describe the interrelated networks, processes and structures that support public health (see Box 1).

2.1 Governance for health and wellbeing

Governance is a slippery term (Marks et al., 2011). The concept of governance for health has been described as 'the culmination of three waves in the expansion of health policy - from intersectoral action, to healthy public policy to the health in all policies (HiAP) approach - all of which are now integrated in whole-of-government and whole-of-society approaches to health and well-being' (Kickbusch and Gleicher, 2012:ix).

These ideas all underpin WHO (World Health Organization) Europe's policy framework and health strategy, Health 2020, endorsed by all 53 Member States in September 2012. In particular Health 2020 recognised that governments can, if they so wish, achieve real improvements in health if they work across government (horizontally and vertically) to fulfil two linked strategic objectives:

- Improving health for all and reducing health inequalities
- Improving leadership and participatory governance for health (World Health Organization Regional Office for Europe, 2012: paragraph 12, 3).

The term 'Health in All Policies' (HiAP) was first introduced by the Finnish government (Leppo et al. 2013) and was taken up by the European Commission when Finland held the Presidency some years ago. The idea overlaps with the whole-of-government and whole-of-society approaches to health and wellbeing. In essence the idea behind HiAP is that 'most of health is created not by the actions of health ministries or the healthcare system, but by many different policies and by actions in society and everyday life' (Kickbusch, 2013:f4283). In practice using the term HiAP can give rise to conceptual confusion and boundary problems and some commentators prefer instead the term 'governance for health and wellbeing' or 'public policies for better health' (Kickbusch, 2013). There

Box 1: What is the public health system?

Thinking about public health as an open system helps demonstrate the complexity and interrelated nature of the issues involved. Oversimplifying reality by breaking problems down into their component parts is often misleading because the very act of unbundling complex issues risks oversimplifying reality and overlooking the interconnectedness of those issues, even when it is these relationships that potentially offer the most critical insights.

An immediate dilemma in talking about a 'public health system' is agreeing a definition of public health and a related set of boundaries (Hunter et al., 2010). Public health is notoriously difficult to define with any precision because its boundaries are not clear and constantly shifting. It is also influenced by changing perceptions of the numerous and varying factors that impact on and shape health. Indeed, there is a great deal of overlap between the 'public health system' and broader societal, environmental, political and economic activity. Use of the term 'public health system' risks ignoring the contribution to the public's health of anything perceived to lie outside this system; however, to include everything under the term would require redefining the whole of the political and economic system as a public health system. This is clearly impractical and not helpful so in using the term we have sought to embrace both those organisations formally charged with taking forward the public health policy and delivery agenda, notably local government but also the NHS and third sector, and the non-governmental agencies and interest groups engaged in lobbying and campaigning in respect of various public health causes.

As a consequence of the intrinsic messiness of public health, the public health system may be thought of as a 'complex adaptive system' which is defined as 'a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents' (Plisek and Greenhalgh, 2001: 626). Complex adaptive systems invariably have fuzzy boundaries, with changing membership and members who simultaneously belong to several other systems, and sub-systems. In such contexts, tension, paradox and ambiguity often occur and cannot necessarily or always be resolved or avoided. More often than not they need to be acknowledged and managed.

is a view that rather than putting health in all policies, all policies need to be aware of their impact on health. Nevertheless, notwithstanding some criticisms, HiAP remains a useful and important concept both nationally and locally.

2.2. The role of local government in public health - the scope for action

Local authorities have a key role in addressing many of the root causes of ill health through their role as place shapers as well as through commissioning and providing local services (Local Government Association, 2010). The Department of Health document 'Local government leading for public health' (Department of Health, 2011) argues that local government is able to take a population perspective, has the 'levers' to promote wellbeing, has expertise in wider public engagement, and can address social determinants and health inequalities. The vision for public health is described as:

- health in all policies
- investing in public health services
- creating healthy environments
- supporting local communities and social networks.

While there exists a growing literature on the role of local government with regard to public health, the field is still developing and the current state of evidence probably reflects the balance of research interests and the absence of the public health specialism in local government in the UK for 40 years. The current strategic priorities that local government needs to focus on to improve health and wellbeing and reduce health inequalities have therefore not been subjected to the same attention by researchers. This can be expected to change quite rapidly with several studies planned or already in progress seeking to understand the new public health system and how local authorities are meeting their new responsibilities.

Much of the research and analysis that has been produced focuses on the social determinants of health and specifically on the following areas:

Built Environment: In 2012, WHO Europe produced a report on the role of local government in addressing the social determinants of health in relation to the built environment

(Grady and Goldblatt, 2012). Evidence emerging from the global Commission on Social Determinants of Health (2008) and the strategic review on health inequalities in England post-2010 (also known as the Marmot Review (2010)) is summarised in this report, and there is an overview of local government policy and practice in England, Denmark, Latvia, the Netherlands, Spain and Sweden. In relation to England, the report notes that 'local councils arguably can have their most important long-term effects on health through the decisions that they take about spatial planning' (Grady and Goldblatt, 2012: 22).

The list of key roles for local authorities within a social determinants framework includes:

- community mobilisation and leadership
- identifying needs and assets
- promoting safe, sustainable places
- commissioning evidence based prevention services
- regulating within devolved local powers
- improving employment conditions for the local government workforce.

A recent study assessed whether local planning authorities 'incorporated health into land use plans and development decisions' (Carmichael et al., 2013). This involved a systematic review (17 studies) and case studies of how UK (mostly English) local authorities covered health issues within project/plan appraisals, such as Strategic Environmental Assessments and Health Impact Assessments, as well as integration of health into core strategies, for example, Unitary Development Plans. Freedom of planning processes allowed some authorities to bring health and wellbeing into over-arching and sub-strategies for cities; two examples are Glasgow Healthy Cities and Plymouth Health Action Zone (HAZ). In contrast, most other authorities only included health objectives and were described as 'mediocre or poor in integrating health into planning policy' (Carmichael et al., 2013: 263).

Transport: The local government public health role and scope for action in the realm of transport policy is analysed by Milne (2012). Two categorisations of transport and public

health interventions are presented which both list options for local government. The first shows the scope of action and maps policy interventions for transport against a 'ladder' of interventions, which ranges from 'do nothing' and monitor the situation through to the highest level of intervention which involves regulation that eliminates individual choice. At the lower levels, where local policies are simply 'nudging' residents to make healthier choices, policy options for local government include provision of school buses or 'Boris bikes', while at the more interventionist end are regulations that compel people to act in specific ways, for example, compulsory speed limits. A second is a matrix adapted from work in the North East of England on transport solutions for health and matches ten types of transport interventions to potential health outcomes, such as reduced road traffic injury or increased physical activity.

Regulation: Regulatory interventions by local government can be used to tackle obesity. The available options for UK local authorities are identified in a review of literature, case law reports and media reports (Mitchell et al., 2011). Options include: regulation of fast food development/street sales; restriction of traffic and promotion of active travel; promotion of physical activity and access to green space. Based on a wide ranging analysis of the UK food policy and governance, it is suggested that local government also has a public health role in terms of local food initiatives, public sector catering contracts and provision of advice to Small and Medium Enterprises (SMEs) involved in the food chain, such as growers (Barling et al., 2002). While regulation can be effective it also raises difficult and contested issues of personal freedom and fairness, which are particularly pertinent if its main impact is on the most disadvantaged.

Multi-sectoral policies: Outside of Europe, policy options for local government around creating better environments for physical activity and healthy eating are examined in an Australian study (Allender et al., 2012). This involved a literature review, a review of policy/practice in municipalities in Victoria, Australia and interviews with a sample of individuals involved in strategy and planning. Eight main areas for policy interventions at local government level are identified: cycling environment; walking environment; land use; access to open space; built environment; advertising; food policy and public liability, but interviews showed that

some areas were seen as less relevant and therefore were less likely to gain political support. Collins and Hayes (2010) review what they term 'scholarly prescriptions for municipal government intervention on local health inequities' (p. 17). Academic literature around healthy cities and urban health was prominent and seven areas of activity by local government are identified.

In summary, it is clear that there are policy areas with a strong evidence base, such as spatial planning, which local authorities should be encouraged to utilise. However, a balance has to be struck between these areas and those where the evidence base is less well developed but the issue is arguably as important, such as developing community resilience or ensuring access to welfare rights advice and advocacy.

2.3. Public health in local government - leadership and implementation

There is a small body of research around the organisation and delivery of public health in England, some of which has looked at local government roles and activities, mostly as part of multi-sectoral, multi-level health initiatives. This research, while acknowledging the value of the local government role, points to the challenges of implementing a social determinants approach within the organisational structures and processes that existed pre-2010.

Going back to the 1990s and public health under a Conservative administration, an evaluation of the 'Health of the Nation' strategy highlights the weakness of an approach not based on social determinants and the value of joint appointments between local authorities and health (Fulop et al., 2000). A 1996 survey of Directors of Public Health (DsPH) and health and local government managers looks at the relative impact of Annual Public Health Reports during this period, particularly in local authority committees (Department of Health et al. 1998; Fulop and McKee, 1996).

Later under the Labour government (1997-2010), greater emphasis was given to a social determinants approach led by primary care trusts (PCTs) but in partnership with local government. But even then there was ambivalence in the government's approach with the rhetoric not matched by the reality. From about 2000 onwards the government's

focus began to shift away from a broad, holistic emphasis on the social determinants of health and towards a growing preoccupation with health care issues (Smith et al., 2009b) and individualistic, behaviour change interventions. This tendency to focus on changing the behaviour of individuals has been described as 'lifestyle drift' (Popay et al., 2010), it is a phenomenon common to many governments, even those ostensibly committed to collective action. The shift also reflected the government's growing attraction to market-style thinking which stressed individual lifestyle issues and underplayed socio-economic determinants of health and the role of government in tackling these (Hunter, 2007). Such a shift was especially noticeable in the second English public health white paper, 'Choosing Health' (Secretary of State for Health, 2004), where the tension between individual versus collective action found favour in a growing emphasis on the former (Hunter, 2005).

A detailed analysis of the interplay between central policy and local implementation of the New Labour health inequalities agenda, based on three area case studies, is provided by Exworthy and colleagues (Exworthy et al., 2002). The article explores how and why national and local expectations around addressing health inequalities were 'dashed' locally, despite those involved welcoming the new direction. More recent qualitative research with individuals involved in decision making on health inequalities and Cardio-Vascular Disease (CVD) (Orton et al., 2011) shows decision makers 'struggling' to keep a public health orientation. Joint public health appointments between health and local authorities are presented as examples of partnership working, but difficulties working across a range of sectors and maintaining relationships are again raised.

A National Institute for Health Research (NIHR) funded study on healthcare commissioning for multi-ethnic populations, based on interviews with individuals involved in commissioning including seven local authority commissioners (Turner et al., 2013), reports on the weak impact of PCT commissioning in relation to health inequalities and the 'failure' of the JSNA (Joint Strategic Needs Assessment) to impact on commissioning practice (p. 7). Research in the North West of England with DsPH and other strategic level stakeholders found that the role of Director of Public Health (some of whom were joint appointments with local authorities) was constrained by external factors and the

lack of workforce capacity (Fotaki, 2007). Themes from two discussion papers on the role of joint DsPH are highlighted in Box 2.

Other research on specific public health issues includes an ethnographic account of Birmingham's response to 2009 swine flu pandemic, which analyses the conflicts between the national centralised approach and the need for local level public health responses, including the key role of local authorities (Chambers et al., 2012). There is also a detailed case study of how one local authority (Lambeth) responded to the growing problem of khat use among a single minority ethnic group (Klein, 2008). The case study describes how the problem was successfully dealt with as a 'complex issue of community relations, public health and community safety'.

In summary, there is a good theoretical base that recognises the importance of a balance between policies that address the social determinants of health, health service provision and individual behaviour change. However, there is a tendency for systems to revert to the default position of focusing on health service provision and individual behaviour change. One of the issues that local authorities should recognise explicitly is that their relationship with their population has greater longevity than most governments and therefore they have a leadership role in developing public health strategies that remain sustainable through changes in government.

2.4. Partnership working for health

Partnerships have been regarded as central to public health for the simple and obvious reason that the majority of challenges facing public health are complex and cross-cutting in nature and involve several policy arenas, organisations and professional groups. Despite this, little is known about public health partnerships since most research is centred on health and social care partnerships (Hunter et al., 2011; Hunter and Perkins, 2012; Hunter and Perkins, 2014). Partnerships in general are not a recent phenomenon and have been a feature of public policy since the 1601 Poor Law. Under the last Labour government between 1997 and 2010, partnership working was a hallmark of its approach to government and a plethora of public health partnerships were established including Health Action Zones (HAZs), Healthy Living Centres, Neighbourhood Renewal Partnerships, Health Improvement Programmes (HImPs) and Local Strategic Partnerships.

Paradoxically, the belief in the value of partnerships is not borne out by the evidence. While they have the potential to make the delivery of services more seamless and coherent, and therefore more efficient and effective, in practice it has proved difficult to conclude that they have had any impact on outcomes. Dickinson and Glasby (2010) note in regard to health and social care partnerships that a series of reviews all conclude that the vast majority of research 'has focused on issues of process, not on outcomes'. The same conclusion was reached in an earlier literature review of partnerships (Dowling et al., 2004). Another systematic review completed through the Cochrane Collaboration (Hayes et al., 2012) looked at evidence of health outcomes resulting from collaboration between local government and local health agencies. Sixteen studies were included in the review; of these four were related to lifestyle behaviours and three to environmental initiatives. The conclusions are that although partnership working between health and local government is 'commonly considered best practice', there is very little evidence indicating that it has any effect on health outcomes (Hayes et al., 2012:2). Despite this, the enthusiasm for partnerships remains undiminished.

The first systematic review of public health partnerships (Perkins et al., 2010, Smith et al., 2009a) reviewed 31 studies, the majority of which were on the impact of Health Action Zones (HAZs) as they proved to be a particularly well-evaluated initiative for which a combination of national and local studies has been undertaken. Other initiatives appraised in the systematic review included Healthy Living Centres (HLCs), HImPs, New Deal for Communities, and National Healthy School Standard (NHSS). Process and outcome issues are identified (Perkins et al. 2010). However, it is important to note that these partnerships all had different purposes - some turned out to have a limited existence (HAZs), others short-lived attempts to produce plans (HImPs), and others community-led development programmes (HLCs).

Further discussion on Health Action Zones can be found in a series of articles based on the National HAZ evaluation (Bauld et al., 2005, Sullivan et al., 2004, Judge and Bauld, 2006). An overview of the development of HAZ initiatives (Bauld et al., 2005) that looks at the challenges faced and progress made comes to the conclusion that while HAZs might be termed a 'policy failure' as they failed to reach aspirational objectives

Box 2: Joint appointments for the Director of Public Health

Describing his experience as a joint DPH in Barnsley, **Redgrave** (2007) notes the considerable variety in arrangements and degree of 'jointness'. In order for a joint post to be successful, Redgrave insisted that a level of enthusiasm within the local authority to tackle health issues was essential. He also stressed the need for joint DsPH to have both the 'political awareness and ability to operate outside their "comfort zone"'. Those appointed must be prepared 'to lead, challenge, persuade, cajole and influence' recognising that they will more commonly have an important influencing role rather than a direct management one.

Elson, based on a career in local government over 35 years, including time as a chief executive and advisor to the Department of Health, argued that while joint posts could work well, 'what matters is how the joint appointment is used and the way the appointee contributes to the development of local policy, priority setting and implementation of the changes needed to improve the health of all citizens, particularly those who are most deprived' (Elson, 2008). Although not research in a pure academic sense, Elson produced six models of practice in respect of joint DPH appointments in order to identify the role that a joint DPH might perform for the council (Elson, 2008). His paper is written from a local government perspective for a local authority audience and takes as its starting premise that most DsPH joining councils have little experience of working in a political environment. The paper explores the subtlety around professional and strategic leadership of health improvement work. It also points out that as local authority structures, cultures and processes differ widely across the country, no single nationally defined role for a DPH is likely to work in all settings. Elson describes six models:

- the expert
- the critical friend
- the adviser
- the provider
- the catalyst
- the community advocate and leader.

The models are not mutually exclusive and different models will be appropriate at different times in different contexts. For these models, Elson identifies the skills required to perform them effectively which go beyond technical expertise in public health which may be taken as a given. Other key areas of expertise include political sensitivity, communication, negotiating and influencing, change management, problem solving and finishing, and leadership. Acknowledging that a different mix of skills will be required in different contexts in local authorities, Elson then aligns the various skills with each of the six models to achieve the 'comfort zone' and best fit between the organisation and the individual.

around health inequalities, local capacity was built and 'change possibilities' were identified (Bauld et al., 2005: 442). This theme is taken up further in research that examines the impact from the perspective of those engaged in a sample of eight HAZs (Sullivan et al., 2004). However, evidence of successful local interventions and outcomes in relation to improved partnership working, public involvement and service changes are all reported.

The realities of working within a complex public health system with a diverse range of organisations and individuals involved is examined through a social network analysis of public health policy organisations in a large UK conurbation (Oliver et al., 2012). Relationships in local networks are more complex than governance structures would indicate and results suggest the 'relative importance of personal relationships over formal hierarchical positions' (Oliver et al., 2012: 102). In looking at perceptions of who had influence and power, or were a source of information/evidence in the public health social networks, managers involved in bridging/brokering connections between organisations and running meetings were seen as most influential, rather than those with executive power. Another study reports on barriers to partnership working in a sample of decision makers at local and regional levels who were working around CVD (Taylor-Robinson et al., 2012). Barriers included lack of shared culture and language and the challenges of dealing with complexity as a feature of policy processes in public health.

2.5. Local democracy and health

Despite the vital democratic function of local government, the review found limited research from England on local democracy and health. The Communities and Local Government white paper 'Communities in Control', which in 2008 set out the democratic renewal agenda of the New Labour government, was accompanied by an Evidence Annex (Department of Communities and Local Government, 2008). This reviews evidence on the nature and extent of citizen participation at a local level, drawing on published studies and national surveys. There is a brief summary on the then health decision making structures and some discussion of social, health and service outcomes resulting from participation in general. Another analysis of democratic structures for health in England compares these with Brazil, where more

active participatory governance mechanisms exist (Barnes and Coelho, 2009). Brazil has over 5000 health councils with community representation organised at municipal, federal and state level.

In England there has been a tendency at government level to focus attention on the role of unitary authorities (either county or metropolitan) and not always pay sufficient attention to the important contribution and potential of district councils. There are 201 District Councils within the boundaries of 27 County Councils and approximately 40% of the country's population resides in district councils. Their health and wellbeing responsibilities include Housing, Environmental Health, Leisure, Planning and Environmental Services (Chartered Institute for Environmental Health, 2012). Similarly, little consideration has been given to Parish Councils and Town Councils who while very small still often play a more significant role than attempts by larger authorities to create area committee or area partnership structures.

Health scrutiny was part of the process of local government modernisation introduced by Local Government Act (2000). The National Primary Care Research and Development Centre at the University of Manchester undertook an evaluation of the implementation of health scrutiny (2002-5), including a pre and post postal survey of local authorities and five case studies (Coleman, 2006, Coleman et al., 2009, Coleman and Harrison, 2006). Coleman (2006), reporting on evaluation results, argues that local government health scrutiny, through bringing communities and partners together, can be a mechanism both to increase local democracy and address cross cutting issues such as health inequalities at a local level. In terms of implementation, conclusions from the national evaluation included: the different local models; positive involvement of expert witnesses; a shift from a focus on health services to broader, cross-cutting public health issues; lack of resources and training; the lack of patient and public involvement and difficulties in connecting to patient and public involvement structures (Coleman and Harrison, 2006). The advantages and disadvantages of types of scrutiny activities (collaboration; corporate activity; challenge and campaigning) are highlighted in a later article (Coleman et al., 2009).

Some of the evidence on community participation in Area-Based Initiatives (ABIs), such as HAZs and New Deal for Communities, has relevance to local democracy and health. For example, a systematic review of community involvement in ABIs commissioned by the Home Office provides a comprehensive review of evidence (36 publications) across a number of aspects of community involvement in ABIs including: aims of community involvement, methods/ approaches, impact and research gaps (Burton et al., 2004). The report includes some specific discussion of HAZs and community health projects.

Overall there is a gap in research on local democracy and health, including on the role of mayors and local politicians/ elected members in public health and the empowerment of communities at ward level to achieve wellbeing.

2.6. Localism and public health

The localism agenda, which has been a feature of both Labour and Coalition government policy, has relevance for public health in terms of seeking to solve 'wicked problems' through a joined up approach at local level. A report on localism for the 2020 Public Services Trust (Charteris et al., 2010), based on interviews and case studies of Manchester and Birmingham, identifies the need for a radically different approach to implementing localism and what is termed 're-wiring of the democratic settlement' (p.18) putting local citizens in charge. Barriers to localism and mechanisms for achieving change, including the value of single 'Total Place' budgets, are discussed in depth with examples relevant to public health.

From a European perspective, the European Regional Policy Document: Cities of Tomorrow (European Union, 2011) reviews potential approaches to sustainable urban development and argues for a holistic approach to governance that links 'place and people based approaches' (vii). Health is discussed in relation to environmental quality, green space and transport mobility. Grady and Goldblatt (2012) also highlight place shaping as a significant approach for public health within a social model of health.

The Total Place Pilots (TPPs) initiative, introduced by the New Labour government, was developed over 12 months in 13 pilots across England all of which were evaluated

(HM Treasury and Department of Communities and Local Government, 2010). Upon learning the lessons from the evaluations, the intention was to roll out the scheme across England but the May 2010 general election stopped that, although interest in place-based or community budgets remains alive. Under the current government the legacy of Total Place continues with initiatives such as 'Whole Place Community Budgets', now known as 'Our Place' (HM Government and Local Government Association, 2013) and in City Deals, which have been developed by the Treasury.

Evaluations of TPPs have been conducted by Grint (2010) and Humphries and Gregory (2010). Detailed evaluation reports of the pilots can be found at <http://www.localleadership.gov.uk/totalplace/news/pilots-final-reports/> and some summary documents are available that synthesise the main themes including health outcomes (Maginn, 2010, Dhar-Bhattacharjee et al., 2010). A recent report by the House of Commons Communities and Local Government Committee also reviews evidence from Total Place and other types of community budgeting and highlights the potential benefits of integrated commissioning of local services (House of Commons Communities and Local Government Committee, 2013a).

The concept of Total Place has its roots in other collaborative, area-based approaches to reconfigure public services to make them more effective at meeting local needs. A review of models of evaluation used in UK area working programmes was conducted in conjunction with the introduction an Area Working initiative in the Wakefield district (Warwick-Booth and South, 2012).

Nine evaluation reports where area working initiatives have been implemented are listed together with outcomes measured. Examples of reported health outcomes are improvements in community capacity and influence as part of participatory budgeting pilots (SQW Consulting, 2010) and health, social and environmental outcomes in the Transforming Your Space initiative (delivered across the UK) (SQW Consulting, 2007).

2.7. New public health structures and organisational change in England

The NHS reforms and the move of public health to local

government are too recent to be evaluated, although there are some early findings from the King's Fund on the introduction of Health and Wellbeing Boards (HWBs) (Humphries et al., 2012), based on a survey of 50 local authority areas and telephone interviews. The follow on report indicates that local authorities have taken a strong leadership role in HWBs; however, there are few signs as yet that the boards 'have begun to grapple with the immediate and urgent strategic challenges facing their local health and care systems' (Humphries & Galea, 2013:1).

There are a number of reports that gather expert evidence/ case studies to underline the benefits of public health moving to local authorities and reiterate the importance of a social determinants approach to health and wellbeing (Solutions for Public Health, 2011, Local Government Association and Department of Health, 2012, Local Government Association, 2010). The House of Commons Communities and Local Government Committee reported on the role of local authorities in health, drawing on a range of evidence both oral and written (House of Commons Communities and Local Government Committee 2013b). Although the Committee acknowledge that local councils are 'well-placed' to support a move to a more social model of health, they conclude that 'they [local councils] will need to use every power, department and service at their disposal, however, if they are fully to grasp this opportunity and tackle the causes of the causes of poor health: the social economic and environmental reasons why people experience ill health or develop unhealthy behaviour' (House of Commons Communities and Local Government Committee 2013b:3).

Another King's Fund report provides a detailed review of health and health care provision in London, based on evidence gathered from interviews and King's Fund seminars (Ham et al., 2013). The focus of much of this report is on health service provision, but there is discussion of the new responsibilities of the London Mayor in the development of a pan-London strategy for health inequalities. Greater Manchester is given as an example of system-wide planning for health and health care. The establishment of the Greater Manchester Health Commission by local authorities is reported to have led to success on issues such as fuel poverty, cycling, obesity (Ham et al., 2013:19-20). Further information on the Manchester Joint Health Unit can be found in two

reports (Hunter & O'Toole, 2000; Mantle & Carey, 2003).

2.8. Learning from other contexts

Most UK research identified in this review has been on local government in England. Health organisational structures are different in the devolved nations. In Scotland, local authorities work with Community Health Partnerships (CHPs) which have responsibility for delivering all primary and community care services. There are also some Community Health and Social Care Partnerships which are integrated structures reporting to both the NHS and local government in an area (Audit Scotland, 2011). CHPs have a statutory duty to 'improve health and tackle inequalities' (Audit Scotland, 2011: 11). An Audit Commission report on CHPs assesses governance and accountability arrangements (including reviewing different models of CHPs); spending and use of resources; impact on population health and quality of life (Audit Scotland, 2011). While it is reiterated that tackling inequalities requires joined up working across a system, the report is critical of the extent to which there has been a shift upstream. Even in relation to moving resources from acute to primary care the report concludes that 'there has been no large-scale shift in the balance of care despite this being a key priority since 2000' (Audit Scotland, 2011:36). More positively, a study of Community Health Partnerships, commissioned by the Scottish Government (Scottish Government Social Research et al., 2010), found that a tradition of partnership working with the local authority was a key facilitating factor in changing patterns of service provision, including orientation to health improvement. No research was reviewed from Wales or Northern Ireland.

Further afield, there is small research literature on local government and public health in Scandinavian countries, which is likely to have limited transferability because arrangements and responsibilities are different. Articles include an analysis of the implementation of national public health policy in Swedish municipalities (Jansson et al., 2011), and overview of nutrition strategies and their implementation in Finland, Sweden and Norway (Roos et al., 2002). There are also case studies of the development and organisation of health promotion in within four Swedish municipalities (Jansson and Tillgren, 2010) and more specifically the development of a smoking prevention and smoking

partnership in two Danish municipalities (Andersen et al., 2010).

An American Public Health Association report (2013), which draws on research conducted in ten case studies of health departments (state and local) across the US, summarises process issues around using policy as a mechanism to promote health. A systematic review of 77 publications categorises organisational features of local and state public health agencies in the US, and summarises evidence on predictors of performance (Hyde and Shortell, 2012). The relationship between organisation/investment in public health services and health outcomes is examined, although the article cautions that more research is needed (Hyde and Shortell, 2012).

Research on local government and public health: what is known? - In a nutshell

Local government has a key role to play in public health and public health is relevant to many of the areas of local government activity. There is wide consensus that whole system approaches are required to address the social determinants of health.

Reviews have identified the options for local government in areas like obesity prevention, active transport and spatial planning.

Research points to the importance of local leadership and effective partnership working in complex public health systems while acknowledging the weaknesses in partnership working processes and the failure to achieve improved outcomes.

There is scope for more research on how local democratic structures can support public health and the health role of elected politicians.

The challenges of implementing a social determinants approach through local government are also experienced in other countries; research on learning and successes could be useful for local authorities in England.

3. PLANNING FOR LOCAL PUBLIC HEALTH - WHAT OTHER MODELS ARE AVAILABLE?

Having reviewed the available social science research relating directly to the local government role in public health in England, this section identifies some additional approaches (evidence-based options) and decision making tools that may be used by local authorities to effect improvements in the health of their communities.

All these approaches can be seen to fit within a social determinants approach to health in local government as discussed earlier (Grady and Goldblatt, 2012, Kickbusch and Gleicher, 2012). We outline the approaches and provide an indication of the strength of evidence. Additionally, the I&DeA (Improvement and Development Agency - now LGA Knowledge) report on the social determinants of health and role of local government (Campbell, 2010) is a useful resource as it contains a number of introductory articles on public health approaches and tools for healthy communities including social marketing, asset-based approaches, scrutiny and enforcement.

3.1. Healthy Cities

The WHO Healthy Cities network has always placed a strong emphasis on political leadership, city health plans and alignment with global health objectives. The European Healthy Cities programme is of particular relevance because UK cities have their own network and are members of this. Indeed, the development of the WHO Europe Healthy Cities Network (EHCN) has led to over 1000 cities being linked either through the EHCN or in their own country networks (Tsouros and Green, 2009). The role of city leadership is critical and Tsouros and Green argue that 'the challenge for cities is not now one of scientific or technical knowhow but of the social and political applications of answers that are already known' (Tsouros and Green, 2009: i5).

There is a wealth of evidence on the implementation and evaluation of healthy cities within the Europe (see for example De Leeuw, 2009, de Leeuw, 2012, Heritage and Dooris, 2009, Plümer et al., 2010). City Health Development Planning (CHDP) was a key methodology for Phase III of Healthy Cities (1998-2002) and different types of approach to CHDP are described in an article based on documentary analysis from 56 European cities (including UK cities) (Green et al., 2009).

In that period, UK cities tended to use an approach that aimed to embed health as a theme into an overall city plan and examples are given. The process of planning through CHDP was found to be successful at raising health on the agenda and bringing greater partnership working and therefore CHDPs can be regarded as a tool to promote 'reciprocal relationships' between health and other sectors (Green et al., 2009: i79).

Further research drawing on the experience of UK Healthy Cities (1997) includes discussion of progress in policy change in a sample of five UK cities and five cities in the Netherlands from the first phase of the Healthy Cities Project (Goumans and Springett, 1997) and an article on the SUPER project (European Food and Shopping Research Project) in Liverpool 1989-1997, which involved multi-sectoral action across a number of local settings (Kennedy, 2001).

Outside of Europe, the California Healthy Cities and Communities (CHCC) initiative provides some interesting comparisons to the European experience (Kegler et al., 2008a, Kegler et al., 2008b, Kegler et al., 2009). Community involvement and community capacity building were strong features of the Californian model. Evidence was gathered from case studies of twenty participating communities across various themes:

- civic leadership and the roles of community representatives in both urban and rural areas (Kegler et al., 2008b)
- policy development and how CHCC coalitions were able to shape policy development and changes in practice (Kegler et al., 2008a)
- community participation, evaluating how CHCCs engaged residents, what factors influenced engagement and whether broad representation was achieved (Kegler et al., 2009).

3.2. Health Impact Assessment

Health Impact Assessment (HIA) is a recognised methodology to incorporate health into decision making and there is an extensive literature to support both the methods and practice. An international review of HIA was undertaken, based on 32 commentary publications and 88 case studies covering a range of sectors and levels of governance (72% of case studies at local level) (Davenport et al., 2006). This identifies a list of factors, both enablers and barriers, relating to the influence of HIA in decision making processes and concludes that the political-administrative environment is a key factor. Guidelines for HIA from across the world are compared in a further review; out of a total of 45 guidelines, 17 are from the UK (including some written for or by local authorities), with 13 from England; two from Scotland; and two from Wales (Herbert et al., 2012).

Some detailed UK case studies of HIA in local government include:

- A community-led HIA on the development of an energy-from-waste plant that took place in an inner-city ward in Cardiff, Wales. HIA methods and outcomes are discussed, although the HIA was not successful at influencing decisions made as part of local authority planning processes (Chadderton et al., 2012).
- A HIA of Edinburgh's transport policy that was able to embed a health inequalities perspective into city transport planning. The results and recommendations are reported (Gorman et al., 2003).
- Four Irish case studies of the role of local government in HIA (Mullane and Quinlivan, 2012); two from Northern Ireland, and two from the Republic of Ireland.
- The HIA conducted in 2000 on the transport strategy of the Mayor of London. HIA methods are described and the impact of the strategy evaluated in terms of policy changes (Mindell et al., 2004).
- A review of the role of HIA in the development of eight London mayoral strategies, covering economic, environmental, spatial and cultural development as well as other topics (Mindell et al., 2010). The review concludes that over time HIA has become a more integrated process in strategy development.

3.3. Asset based approaches

Interest in asset based approaches has grown in local government in England since the publication of the Improvement & Development Agency (IDeA) 'A Glass Half Full' (Foot and Hopkins, 2010). Asset based approaches seek to identify the strengths, capacities and skills within communities and build activity based on these assets rather than focusing on community needs and deficits (Foot and Hopkins, 2010). A National Colloquium (Solutions for Public Health, 2011), involving leaders from public health, local authorities and primary care, summarised the value of a 'co-production approach', and made a number of practical recommendations including the adoption of asset based approaches to community engagement. There are various

methods and techniques associated with asset based approaches (Foot and Hopkins, 2010; Foot, 2012) including:

- Asset mapping
- Asset Based Community Development (ABCD)
- Appreciative inquiry (AI)
- Open Space Technology
- Social prescribing
- Time banking.

While there is a strong theoretical justification for the adoption of asset based approaches that promote positive/protective factors for health (Morgan and Ziglio, 2007), there is a lack of research evidence from England about the role of local government, perhaps because this is still quite new to practice. Two reports provide detailed discussion on the methods, learning and outcomes from asset based approaches in health that have involved local councils; one reporting on an asset mapping pilot in two communities in Wakefield district (Greetham, 2011), and the other drawing on examples in the North West region (Nelson et al., 2011). Outside of the UK, an ethnographic case study from Erlangen, Germany, looks in detail at the application of an asset based approach (Rütten et al., 2009) at neighbourhood level in order to improve access to local sports facilities for disadvantaged women. The paper reports on the involvement of local women, local politicians, municipal services and local community organisations and also draws wider lessons on the value of asset-based approaches.

Currently, there is some development work on approaches aiming to capture assets as well as deficits to inform public health. Examples include: the development and piloting of a low cost easy to use Rapid Review methodology that can be used by the voluntary and community sector, led by Yorkshire and Humber Public Health Observatory (now part of Public Health England); further work on asset based approaches commissioned by the Health Foundation; and work on fostering system level asset based frameworks developed by Greenwich Council and the University of East London.

3.4. Joint Strategic Needs Assessments

Local Health and Wellbeing Boards are responsible for producing the Joint Strategic Needs Assessment (JSNA), which is intended to underpin the development of the Joint Health and Wellbeing Strategy. There has been comparatively little research reviewing the impact that JSNAs have made on commissioning, however, a review of JSNA commissioned by Yorkshire and Humber Public Health Observatory in 2012 (Gamsu and Abbas, 2012) concluded that JSNAs have struggled to make a systematic impact on commissioning. JSNAs have tended to be built around national indicator sets, bringing attendant strengths (e.g. use of consistent data that can be used to compare need and performance with others) and weaknesses (e.g. government data sets which are predominantly quantitative and weak on contributions of key sectors like the voluntary sector). The sheer scale of JSNA data often makes them hard to access and understand.

What is probably most important is that the duty to produce a JSNA has created a greater expectation that commissioning actions should wherever possible be based on intelligence that considers population need and impact. There is a growing recognition that the JSNA is as much to do with a way of working that places data in all its forms (quantitative, qualitative, deficit, asset) at the heart of commissioning and through so doing makes decision more transparent and inclusive.

3.5. Local government commissions

A growing number of local authorities are developing holistic strategies to address health inequalities by 'starting at the other end' by asking broad questions about how prosperous or fair their borough is, instead of considering how to address health inequalities in isolation. The model is broadly to establish a commission which incorporates elements of approaches used by local authority scrutiny committees and government select committees.

Commissions generally place an emphasis on a local holistic view of place, testing priorities through public, stakeholder and expert dialogue, cross sectoral and cross party engagement. Local authorities who have taken this approach include Islington, Camden, Sheffield, York, Wakefield, Newcastle and Liverpool. 'Asking the difficult questions, making the difficult decisions' (Gamsu and Abbas,

2013) summarises the commission model. Plans produced by commissions have seen actions on health inequalities aligned with those on prosperity, housing and social mobility. For example, the 'Poverty and Prosperity' commission, which was conducted jointly with Wakefield Together (the district partnership) and Leeds Metropolitan University, examined local evidence on health and wellbeing, post 16 skills and education, and regeneration and employment. This resulted in a set of solution focused recommendations (Leeds Metropolitan University and Wakefield Together, 2012). In Kent, a similar approach with a different but related purpose was taken by Kent County Council, Dover District Council and local GPs to develop a co-produced approach to the government's health and care reform agenda (Kent Health Commission and Localis 2012).

3.6. North American models

While the national policy context is very different, the United States experience at local authority (City and County) level has much to offer. This is in part because of the arguably greater importance of local democracy in the US compared to the more centralist governance in the UK. The evidence generated from a decentralised approach may become more relevant given the drive to localism here (Charteris et al., 2010). Based on a literature review of 36 publications, a case is made for action by US local public health departments around a social determinants approach based on building social networks (Hunter B.D. et al., 2011). While the article acknowledges that there is more work to be done in understanding the pathway between social capital and health outcomes, three local level approaches are identified: asset based approaches, Healthy Cities and community building (community development). Two case studies from California, which are relevant to the context in England, are discussed in depth:

- an asset based approach building community assets, including local services such as libraries and schools (Payne and Williams, 2008)
- a Healthy Neighbourhoods Project based on community building methods led by a cohort of community organisers and neighbourhood health advocates but with engagement by local politicians and local officers (El-Askairi and Walton, 2004).

Other interesting examples of work from North America fitting with a social determinants approach include:

- University of Wisconsin on County Health Rankings (University of Wisconsin, 2013). The model is particularly interesting because it provides a simple way of comparing health and wellbeing against Health Behaviours, Clinical Care, Social and Economic Factors and Physical Environment, with a clear view about the relative importance of each of these areas.
- 'Let's start a conversation about health and not talk about health care at all' (Sudbury and District Health Unit, 2013), a video adapted by many counties in Canada which initiates a dialogue about the social determinants of health targeted at people who do not have a full understanding of the role that the social determinants of health play.

Working models - In a nutshell

There are a range of approaches/methods that local government can use for public health planning and implementation or for incorporating health into planning processes.

One of the key issues is the important role of city leadership - at political level - which pulls together local authority services and other agencies as well as providing some continuity in the face of changing government policy.

Established methods where there is an evidence base, with evaluations/case studies from local authorities in England include:

- Place level strategic leadership - Healthy Cities and Health Scrutiny and newer approaches where the UK evidence base is still developing such as local government commissions on the social determinants of health
- Multi-sectoral Commissioning - Total Place and community budgeting and newer approaches such as asset based working/asset mapping
- Tools for change - Health Impact Assessment
- Area-Based Initiatives, e.g. Health Action Zones.

4. EVIDENCE AND PUBLIC HEALTH

Evidence in public health is a contested concept, meaning that there is considerable debate over what counts as evidence, what is the best type of evidence, and in what contexts different sorts of research designs should be used.

There are also issues around how evidence is best presented and key messages conveyed. Evidence will always be only one among many factors influencing decision-making and rarely the most important one.

One of the key issues for local government is that evaluative research needs to take into account the complex, multi-sectoral nature of much public health action (Smith and Petticrew, 2010). Interventions may focus on social determinants at a system or area level and will usually involve, as discussed earlier, multiple partners and types of activity. This makes it difficult to tease out the effectiveness of single elements of any intervention or strategy; it is often the synergy from parts working together that achieves change. The long term nature of change processes and outcomes at a societal or system level also need to be considered (Smith and Petticrew, 2010). All of these issues mean that the approach to evidence associated with health services or clinical interventions does not fit well with the information needs for local government. This section summarises some of the major sources of public health evidence of relevance to local government in England and highlights current research programmes.

4.1. Sources of evidence

Public health evidence can be broadly grouped into evidence about the scale, scope or cause of a problem and evidence about whether and how interventions (in their broadest sense) work, (Rychetnik et al., 2002). The former is dominated by epidemiology (which is not covered in this review), while the latter covers a much broader and diverse body of knowledge ranging from policy analysis to project evaluations. Current debates on public health evidence more generally point to the importance of taking a broad approach to evidence, using both quantitative research designs and qualitative studies (National Institute for Health and Care Excellence, 2012, Petticrew et al., 2012).

The Strategic Review of Health Inequalities in England post-2010, 'Fair Society, Healthy Lives' (Marmot Review, 2010), brings together epidemiological evidence about health inequalities and their social determinants in England and evidence on strategies to narrow the health gap. Six policy objectives (Box 3) form the framework for evidence-based recommendations for the development of policy and practice. The role of local as well as central government is emphasised within the review. The UCL Institute of Health Equity, which is taking forward the work of the Marmot Review, is developing an evidence base for tackling health inequalities. Their website (<http://www.instituteofhealthequity.org/home>) has a search facility with access to a wide range of evidence sources and reports of relevance to local authorities. NICE, the National Institute for Health and Care Excellence, is a

major source of evidence on public health interventions. Kelly and Moore (2010) summarise the work of NICE in public health and the range of evidence guidance and other resources available in a chapter in the I&DeA report on the social determinants of health and local government (Campbell, 2010). Key points about the nature of evidence, how NICE reviews evidence, its relevance to local government and recommendations for evaluation are made (Kelly and Moore, 2010). NICE has started to produce briefings for local government, intended to represent its public health guidance (all 37 pieces of it) in a format that is easily accessible to various local government audiences, including elected members. They are available on the NICE website (www.nice.org.uk). NICE's remit now includes social care so as an organisation it is striving to relate to and face local government much more. NICE's rebranding and name change - still NICE but with Care instead of Clinical - relate to this.

This rapid review and the attached bibliography list relevant research, policy reports and websites around the role of local government and public health. There are a number of literature reviews and systematic reviews that cover aspects of the local government role in public health. Reviews provide very useful sources for further information and research as well as giving an overview of key themes or evidence around a topic or topics. Some reviews focus on gathering the learning from practice. Systematic reviews are a specific type of literature review as they aim to locate and synthesise all the research that bears on a particular research question using organised, transparent and replicable procedures at each step of the process. Good systematic reviews take precautions to minimise error and bias so firm conclusions can be drawn. Evidence from systematic reviews is highly regarded, although sometimes, because of the processes of sifting out research that does not meet set criteria, they lead to conclusions about insufficient evidence which are not much use to policy makers (Petticrew, 2003). A list of systematic reviews included in this rapid review is given in Box 4.

Box 3: Reducing health inequalities - six policy objectives

(source: Marmot Review, 2010)

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

Box 4: Systematic reviews included in rapid review

BURTON, P., CROFT, J., HASTINGS, A. & SLATER, T. 2004. What Works in Community Involvement in Area-Based Initiatives? A Systematic Review of the Literature, Research Report, No. 53. London.

CARMICHAEL, L., BARTON, H., GRAY, S. & LEASE, H. 2013. Health-integrated planning at the local level in England: Impediments and opportunities. *Land Use Policy*, 31, 259-266.

HAYES, S. L., MANN, M. K., MORGAN, F. M., KELLY, M. J. & WEIGHTMAN, A. L. 2012. Collaboration between local health and local government agencies for health improvement. *Cochrane Database of Systematic Reviews*.

HYDE, J. K. & SHORTELL, S. M. 2012. The Structure and Organization of Local and State Public Health Agencies in the US: A Systematic Review. *American Journal of Preventive Medicine*, 42, S29-S41.

SMITH, K. E., BAMBRA, C., JOYCE, K. E., PERKINS, N., HUNTER, D. J. & BLENKINSOPP, E. A. 2009. Partners in health? A systematic review of the impact of organisational partnerships on public health outcomes in England between 1997 and 2008. *Journal of Public Health*, 31, 210-21.

Case studies can offer a useful way of understanding how different approaches work in local contexts. The strengths and limitations of using existing case studies to understand effective action on health inequalities are discussed by Simpson and colleagues (2013). They suggest that case studies can provide a source of relevant information and propose a checklist to aid policy makers and practitioners appraise a case study on action on social determinants of health to reduce health inequalities. Expert evidence can be a useful way of understanding current thinking or difficult issues and this can happen in participatory structures, such as expert hearings (South et al., 2011) or commissions (Gamsu and Abbas, 2013) as well as through written reports.

Crucially, local government evidence on public health needs to include the citizen voice. Incorporating a community or public perspective into public health evidence can be achieved

through a variety of means, including: consultation methods; health needs assessments; primary research (e.g. undertaking surveys, interviews and focus groups); democratic mechanisms such as health scrutiny (Coleman and Harrison, 2006); Health Impact Assessment (Chadderton et al., 2012); participatory/community budgeting. In January 2014, a national conference 'Putting the public back into public health' debated how the voice and experience of citizens can be an integral part of the evidence on which to base public health practice.

Finally, consideration needs to be given to how evidence can be applied in local government and can inform decision making and practice. A knowledge translation intervention to increase use of health promotion evidence in local government in Victoria, Australia (Pettman et al., 2013) identified barriers experienced by practitioners in local government including: difficulties accessing evidence, a lack of culture of using evidence. Practical approaches are proposed to address barriers including workforce development and access to academic databases.

4.2. Current and ongoing research

The NIHR School of Public Health Research (SPHR) has funded three projects that are well underway. Full details can be found on the School's website (<http://sphr.nihr.ac.uk>). Two in particular may be of particular interest to local authorities. First, a team based at the London School of Hygiene & Tropical Medicine (contact: Karen Lock) is leading two linked studies under the overall theme 'Cultures of evidence beyond the health sector: Understanding policy decision-making in English local government for improving action on social determinants of health'. The aim of the research is to engage with local government stakeholders in the production of new evaluative research focused on their evidence needs and appropriate to their decision-making processes. The studies are nearing completion and are being written up. Second, a team based at Durham University (contact: David Hunter) is leading a study called 'Shifting the gravity of spending? Exploring methods for supporting public health commissioners in priority-setting to improve population health and address health inequalities'. The aim of the research is to develop support for local authority based public health commissioners in prioritising investment in health improvement and tackling inequalities, as well as in deciding upon disinvestment strategies. The study should

be completed by mid-2015 although regular updates and presentations are posted on the project website (<http://www.shiftingthegravityofspending.org.uk>). A scoping study of approaches for decision support to assist in the prioritisation of public health intentions in local authorities is available on the website.

The SPHR has also launched the Public Health Practice Evaluation Scheme (PHPES) which will involve SPHR members in the evaluation of innovative projects or initiatives being implemented by public health practitioners working in different sectors. The School's purpose is to address the challenges faced by public health practitioners working on the frontline across local government and the NHS. PHPES will draw on the academic skills within SPHR to conduct rigorous evaluations of innovative initiatives and their cost-effectiveness.

The Department of Health (DH) Policy Research Programme's Health Reform Evaluation Programme (HREP) is in the process of selecting proposals for funding and a number of projects, including at least one examining aspects of the new public health system. It will be February or March 2014 before these proposals are either selected for funding or rejected. A second call for proposals under the HREP appeared in late November and while there is some emphasis on public health, notably in respect of the workings of Health and Wellbeing Boards and the impact of the public health outcomes framework, most of the call is focused more narrowly on the impact of the NHS changes. In addition, the DH funded Policy Research Unit in Commissioning and the Healthcare System (PRUComm - a joint venture between the Universities of Kent and Manchester - contact: Stephen Peckham) has started a project examining the new public health system in England. Its purpose is to examine changes in the public health system as a whole, the impact of the reforms on the system, and some of the key facilitators and barriers to achieving policy goals. The project is taking obesity as a tracer issue to understand and illustrate the workings of the new system. More information about PRUComm's work is available at www.prucomm.ac.uk.

Public health evidence - In a nutshell

Public health evidence should not be defined narrowly as it covers a very diverse body of knowledge ranging from epidemiological research to case studies and community consultations.

This rapid review has identified many reports and articles that review of evidence around specific topics relevant to the local government role in public health.

NICE produces guidance on public health interventions for local authorities and the UCL Institute of Health Equity has many resources on the social determinants of health.

New research is looking at how well aspects of the new public health system are working.

5. CONCLUDING REMARKS

This rapid review was commissioned through the ESRC Local Government Knowledge Navigator initiative.

Its purpose was to map available research-based information that could be used by local government decision makers in developing their public health function in the new system. Our challenge was to do this in a way that acknowledged the complexity of public health but at same time was able to summarise key themes or approaches. Inevitably there are limitations to the rapid review process. Nonetheless the results presented here demonstrate that there is a body of existing knowledge about the local government role in public health and also research gaps for future exploration.

The social determinants approach to health and wellbeing is the natural territory of local government and the review has highlighted the scope for action. Hopefully, it will be used as a resource to signpost to research that can provide some of the frameworks for action within a social determinants approach. In a period of profound change, the review may also provide some food for thought and a starting point for discussion about strategic direction around the public health agenda including how cost-effective interventions can be promoted through the new Health and Wellbeing Boards.

Further information

Further information on the methods used in this rapid review can be found in Annex A at the end of the document.

A full bibliography on local government and public health accompanies this review.

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Notes on the methodology used in preparing this review is available on request.

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Additional Web resources

ECONOMIC AND SOCIAL RESEARCH COUNCIL. ESRC research investments: health and wellbeing. <http://www.esrc.ac.uk/research/major-investments/health-wellbeing.aspx>

LOCAL GOVERNMENT ASSOCIATION - Health. <http://www.local.gov.uk/health>

LOCAL GOVERNMENT ASSOCIATION and DEPARTMENT OF HEALTH. From transition to transformation in public health - update. An updated resource to assist the transfer of public health to local authorities. http://www.local.gov.uk/health/-/journal_content/56/10180/3374673/NEWS

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE. NICE support for local government. <http://www.nice.org.uk/localgovernment/Localgovernment.jsp>

NHS HEALTH SCOTLAND. <http://www.healthscotland.com/>

NATIONAL INSTITUTE FOR HEALTH RESEARCH (NIHR) PUBLIC HEALTH RESEARCH (PHR) PROGRAMME. <http://www.nets.nihr.ac.uk/programmes/phr>

NIHR SCHOOL FOR PUBLIC HEALTH RESEARCH. <http://sphr.nihr.ac.uk/>

POLICY RESEARCH UNIT IN COMMISSIONING AND THE HEALTHCARE SYSTEM (PRUComm). <http://www.prucomm.ac.uk/>

PUBLIC HEALTH AGENCY (OF NORTHERN IRELAND). Health and social wellbeing improvement. <http://www.publichealth.hscni.net/directorate-public-health/health-and-social-wellbeing-improvement>

PUBLIC HEALTH ENGLAND. <https://www.gov.uk/government/organisations/public-health-england>

ROYAL SOCIETY FOR PUBLIC HEALTH. <https://www.rsph.org.uk/>

THE KING'S FUND. Public health and inequalities. <http://www.kingsfund.org.uk/topics/public-health-and-inequalities>

THE CENTRE FOR TRANSLATIONAL RESEARCH IN PUBLIC HEALTH. <http://www.fuse.ac.uk/shifting-the-gravity-of-spending%3F-3131>

UCL INSTITUTE OF HEALTH EQUITY. <http://www.instituteof-healthequity.org/>

UK FACULTY OF PUBLIC HEALTH. <http://www.fph.org.uk/>

UK HEALTHY CITIES NETWORK. <http://www.healthycities.org.uk/>

WELSH GOVERNMENT - Health and Social Care. <http://wales.gov.uk/topics/health/?lang=en>

WORLD HEALTH ORGANIZATION EUROPE. Health 2020: the European policy for health and well-being . <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>

Abbreviations

ABI	Area-Based Initiative
CHPs	Community Health Partnerships
CVD	Cardio-vascular disease
DH	Department of Health
DPH	Director of Public Health
HAZ	Health Action Zone
HIA	Health Impact Assessment
HiAP	Health in All Policies
HImP	Health Improvement Programmes
HLC	Healthy Living Centre
HWB	Health and Wellbeing Board
JSNA	Joint Strategic needs Assessment
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
PCT	Primary care trust
TPPs	Total Place Pilots
WHO	World Health Organization

Annex A: Rapid review methods and search strategy

1) Rapid review scope

The focus of the review was on the role of local government in developing a local public health system and addressing the social determinants of health. The review sought to identify relevant social science research in order to highlight different options for local authorities within a broad framework for public health action. The approach was to map sources of research-based information and to provide some critical commentary that would allow readers to navigate through different types of evidence. Due to the wealth of epidemiological evidence available at national and local levels, the review did not cover patterns of health or disease, causal factors nor evidence around specific health issues. Questions of the effectiveness and cost-effectiveness of specific interventions were not covered.

2) Review objectives:

The broad aim of the review was to locate and summarise social science research on the role of local government in public health and the scope for intervention across a district. There were three review objectives:

RO1: To provide an overview of research on governance for health at a local government level, including the role of local politicians.

RO2: To identify working models that may allow local government to effect improvements in the health of their communities.

RO3: To provide a critical commentary on the types of evidence that can be used to inform local government action on public health.

3) Review methods

Rapid review methods were used to identify key sources of research-based information within a short time scale. Three stages were involved: searching; study selection; narrative synthesis of themes.

a) Search strategy

The search strategy was based on rapid review methods and sought to identify the best available evidence, including where research has already been gathered and reviewed. An initial search strategy was devised that listed relevant databases, websites and key search terms, which were agreed between all three reviewers. Results from the initial search allowed the search strategy to be refined and a second search was then undertaken. In addition to the search, relevant sources were identified by each reviewer.

Evidence sources

i. Academic databases

Web of Science [including social science databases and citation indexes]

CINAHL

Pub Med

ii. Relevant websites and other evidence sources

WHO Europe

European Commission

Health Scotland

Welsh Assembly

Public Health Agency of Northern Ireland

Department of Health

Department of Communities and Local Government

Home Office

NICE - public health evidence

ESRC

Social Policy Association

Local Government Association

UCL Institute of Equity

The King's Fund

Faculty of Public Health (UK)

NIHR including NIHR School for Public Health Research

DH's Policy Research Programme

American Public Health Association

iii. Documents identified by research team/other experts

Search terms

A combination of search terms was used: Local government string AND public health string AND review limiters if needed (Table A). Search dates were from 1993 onwards to yield a range of publications, including UK research on policy/programmes introduced during the New Labour administration. Website searches were used to try and identify the most recent studies/reports on changes brought about by the Coalition Government e.g. Health & Wellbeing boards.

Annex A: Rapid review methods and search strategy

Table A: Search terms

Local government	Public health	Review limiters
Local government	Health promotion	Title: Review, model, study/ studies, research, framework [if needed]
Municipalit*	Governance [within 5 words]	Search dates RO1 &2: from 1993 RO3: from 2003
Local authorit*	health	Country limiters : RO1: UK, pan-European RO2: As above and North America, NZ, Europe, Australia. RO3: As RO1
Council*	Health system*	
Elected member*		
Mayor*		
Local democracy		

For RO1: Limiters were used to identify reviews (systematic and non-systematic) and good quality primary research studies. Limiters were used to identify UK or pan-European research, and international reviews covering these geographical areas.

For RO2: Specific searches were run for the following models as these have been associated with local government public health:

- Wellesley Institute -Advancing urban health
- Labonte framework
- European Commission on municipalities
- Healthy Cities/setting approaches
- Public health system/systems thinking
- Asset based approaches
- Health Impact Assessment
- Health Equity Audit

b) Screening and selection for inclusion in review

Titles were first screened for potential relevance to the review questions. Titles and abstracts were then screened by two researchers independently, who produced an initial list of included studies. Full papers were retrieved where relevance was unclear. Specific publications identified by the other two reviewers or through web sites were included at this point. An Endnote library was created to track and categorise studies.

The next stage was to produce a map of the evidence and cross reference studies to each review question. For RO1, the priority was to select research-based literature from the UK (England, Wales, Scotland and Northern Ireland) and reviews on local government and health produced by European agencies. This ensured that review findings were of relevance to the local government context within England and that the review was manageable in terms of size.

A further selection took place as full papers were entered into the review process to ensure a manageable number of publications in the review and exclude papers where there was duplication (e.g. the topic search on Healthy Cities search yielded a large number of European papers, some of which were recent reviews therefore could be expected to cover earlier research). The final list was agreed by all three reviewers.

c) Narrative synthesis

This stage involved summarising the scope and nature of social science research under each review objective. Within the constraints of a rapid review process, the reviewers assessed the weight of evidence around specific topics, its relevance/transferability to local government in England and noted any research gaps. For RO1, the analysis was structured to move through different levels of governance from a 'whole-of-society, whole-of-government' approach to ward/ community level. For RO2, the aim was to produce descriptive summaries of the most prominent working models of doing public health in local government and to signpost to further sources of information. The final narrative was agreed by all three reviewers.