UK HEALTHY CITIES NETWORK

THEMED LEARNING EVENT:
LEADERSHIP & GOVERNANCE FOR HEALTHY CITIES
WEDNESDAY 09 JULY 2014
MANSION HOUSE, NEWCASTLE-UPON-TYNE

REPORT

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EVENT OBJECTIVES

- To explore how innovative approaches to and applications of shared and participatory
governance within Healthy Cities can foster whole-of-government and whole-of-society solutions
and help to embed health and health equity in all policies
- To examine leadership within Healthy Cities and discuss its role in developing and enabling the
effective delivery of creative forms of governance.
- To identify priorities for future action at local and Network levels.

PROGRAMME

Chair: Dr Eugene Milne, Director of Public Health – Newcastle-upon-Tyne

10:15  Registration and refreshments
10:50  Welcome and Introductions
11:00  Governance for Health Equity in Healthy Cities
      - Dominic Harrison, Director of Public Health, Blackburn with Darwen
11:30  Leadership for Health
      - David Hunter, Professor of Health Policy and Management, Durham University
12:00  Panel Discussion: Reflections on Keynote Presentations and Implications for Practice
      Facilitated by Steve Park, Assistant Director of Policy and Communications, Newcastle City
             Council
      - Dominic Harrison, Director of Public Health, Blackburn with Darwen
      - David Hunter, Professor of Health Policy and Management, Durham University
      - Cllr Bernard Peters, East Staffordshire Borough Council
      - Cllr Mel Speding, Sunderland City Council
      - Helen Wilding, Newcastle City Council
      - Sharon Miller, ABM University Health Board, Swansea
12:30  Lunch and Co-ordinators’ Meeting    Lunch and Politicians’ Meeting
14:00  Round Table Discussions
      Introduction by Helen Wilding, Wellbeing for Life Development Lead, Newcastle City
             Council (on behalf of Organising Group)
      - How far have your cities/towns and health and wellbeing boards come in developing
effective leadership and governance for health and wellbeing?
      - What has / hasn’t worked well – and what examples can you give of politicians, officers
and others working together to ensure effective leadership and governance for health
and wellbeing?
      - How can Healthy Cities (locally and through the UK Network) help to move things
forward and enhance leadership and governance for health and wellbeing?
15:15  Feedback
15:30  Refreshments
15:45  Discussion and Priorities for Future Action [for those able to stay]
16:30  Close
WELCOME

Cllr. Ann Schofield

It’s a great privilege to welcome you to Newcastle and to our historic Mansion House – the official residence of the Lord Mayor since 1887.

We are particularly proud to be hosting today’s learning event and excited by the opportunity it gives us to share ideas from the findings of research, practice and experience on how we can work together to:

- provide excellent leadership and governance for our cities to ensure they are healthy cities for all
- ensure we have shared indicators and measurements of success and obstacles to success
- share best practice on how to embed the Healthy City attributes (governance; equity; partnership; leadership; participation; policy making and action) in a way that connects our strategic and operational levels of work within and between our cities – we all know of strategies gathering dust in cupboards.

It’s a bit clunky, but the WHO definition of a Healthy City (originally by Hancock and Duhl, 1988) provides us with a useful guide for our thinking and discussions today:

“One that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all functions of life and in developing to their maximum potential.”

A 1999 paper by Werna et al is also helpful in its challenge that

“the real success of any Healthy City project is when it ceases to be a project because the system is set up to ensure that health issues are given priority, to involve all stakeholders and to ensure that all sectors recognize their role in healthy cities becomes part of the structure of local governance.”

Newcastle is on a strategic and implementation journey which began in the early 1990s when we first connected with the Healthy Cities Movement (we became a WHO-designated city as part of Phase III). Prior to 2009, like other local authorities, we had an established strategic partnership with a focus on wellbeing and health that work to provide a JSNA for the city that would be delivered by different parts of the partnership, but there was little content relating to the social determinants of health and the impact of health inequality on people’s lives within the city and the region (within eight miles across the city, there is a 14-19 years difference in healthy life expectancy).

We knew a step change was needed if we were to address the health needs of our city and can chart key stages on this journey. Rethinking governance and leadership (political, academic and organisation across all sectors) has been crucial in getting us to the point we are at today: bringing social determinants of health to the centre of health promotion and medical practice.

Political commitment to the Healthy City agenda in Newcastle is going from strength to strength. Also, our membership of the European Healthy Cities Network and the Healthy Ageing Sub-Network has ensured we continue to innovate and drive forward our agendas for change and provides a benchmark for our progress against leaders in the field. Thanks are due to our coordinators Helen and Barbara.

There are four key areas driving us to new ways of working together through leadership and governance:

1. Establishment of the Wellbeing for Life Board (a powerful strategic partnership across all sectors) that has agreed to go above and beyond the statutory health and wellbeing requirements.
2. The broader Newcastle Future Needs Assessment approach, ‘Know your City, Know Your Community’, which shows the wide ethnic diversity, draws attention to the changing demographic of the city and the inequities in healthy life expectancy across different
communities and so gives us indicators of what must be done to continually create and improve physical and social environments and expand community resources for people of all ages and ethnicity in the city.

3. The provision of a framework ‘Let’s Talk’ (including – very importantly – a shared language) for collective action around wellbeing and health that involves a wider set of stakeholder views than in the past including those of local people in the health of the city; social prescribing; community building; and preventative and early interventions by services.

4. Expanding our emphasis more recently to include involvement in the WHO Global Age Friendly Cities Programme, to raise the visibility of the changing demographic and its impact for the city – linking the built environment; the use of digital technology and inclusion; and work and the economy as indicators of how we need to work differently to address it (e.g. the fastest growing group of the population is the over-90s).

Today is about how we create healthy and inclusive cities through leadership and governance for our current and future populations. It is a big challenge and hopefully, today’s discussions will show we are ready to meet it.

Publications referred to in presentation:

GOVERNANCE FOR HEALTH EQUITY IN HEALTHY CITIES
Dominic Harrison, Director of Public Health, Blackburn with Darwen

Link to PPT Presentation

Dominic explored the governance of health risk conditions – defined as ‘social, economic, environmental and cultural policy and settings which drive individual health risk factors (behaviours, lifestyle etc.).

He presented four ‘problem hypotheses’:

- Inequalities in healthy life expectancy are the key issue driving avoidable health and social care system demand.
- Preventable ‘health risk conditions’ are driving this demand and these are disproportionately affecting the poorest 15% of the population.
- The health and social care system is not structured to meet this challenge, is not evidence based, it is allocatively inefficient and it is now in a financial crises masking a ‘conceptual emergency’
- We need a new form of ‘health governance’ (not just healthcare systems governance) if we are going to control health risks and health and social care system demand.
He argued that current governance focuses on the health and social care system and on health risk factors – and that there is a ‘governance gap’ in relation to health risk conditions (examples of which are debt, food poverty and social isolation). He highlighted problems relating to welfare reform and ‘austerity employment’ and ‘precariat-isation’ – and also discussed what he termed a ‘narrative misdirection in public health: whilst we continue to talk about ‘consumer food choice’, the reality is ‘multi-national controlled choice architecture’ and the dominance of ‘commercial determinants’, which links strongly to the growing crises of diabetes and obesity.

Touching on issues of condition management and self-care, he contended the state and the community play key governance roles and that there is a need to reconsider ‘allocative efficiency’ and to reinvest in primary and neighbourhood care and ‘healthy public policy’.

Focusing on the shortcomings of current governance for health equity, he drew on his recent co-authored WHO publication ‘Governance for Health Equity’ to suggest that there were four key ‘failures’ – conceptual, delivery chain, control strategy and public health system. Building on this, he suggested that transformational and innovative governance needs to operate at be multiple levels and across the all sectors of society – and would be characterised by:

- Modernised and strengthened public health systems
- Governing through collaboration
- Governing through citizen engagement
- Governing through a mix of regulation and persuasion
- Governing through independent agencies and expert bodies
- Governing through adaptive policies, resilient structures and foresight.

Looking ahead, Dominic suggested that we need to:

- Manage risk conditions in the social and commercial determinants of health more effectively
- Re-conceptualise the health and care system to include both monetised and non-monetised systems
- Radically disinvest from hospitals (as we know them) into primary care and community ‘capacity and enablement’
- Develop an integrated public sector/third sector offer in neighbourhoods and communities
- Develop a ‘New Health Governance System’. This should be led by an evolved /redefined Health and Wellbeing Board.

Publications referred to in presentation:


LEADERSHIP FOR HEALTH

Prof. David Hunter, Professor of Health Policy and Management, Durham University

Link to PPT Presentation

David presented a critical overview of leadership, highlighting:

- A lack of understanding about what leadership is
- A misplaced focus on development of individual leaders rather than on leadership
- An assumption that leadership is context-free
- An over-emphasis on competence rather than capacity

He suggested that the current leadership challenge facing us acknowledges:
- The existence of ‘wicked problems’
- The value of a whole systems approach
- The political nature of complex systems

He outlined three types of leadership problems:
- **Type I:** Problem definable and can be solved with technical knowledge and expertise
- **Type II:** Problem is clear but solution is not
- **Type III:** No obvious definition of the problem or solution

Of these, Types II and III situations are complex, cross-boundary and hard to solve.

David contended that leadership needs to be understood as a process focused on collective capacity (moving away from traditional focus on ‘leaders’ and ‘followers’) – and that new approaches to and styles of leadership are of necessity:
- Adaptive
- Distributed
- Engaged
- Integrative
- Collaborative

This will involve a shift away from providing answers to asking questions and facilitating conversations.

Drawing on an Institute for Public Policy Research report, David went on to highlight the failure of ‘New Public Management’, which has created fractured public service systems and prioritised bureaucracy and markets. In addressing complex and wicked challenges, there is a need for greater interconnectedness in policy and practice and for the ‘foregrounding’ of context in the study of leadership.

Drawing on the analogy of jazz, he emphasised the importance of balancing structure with innovation within particular contexts. In concluding, he focused on the need for systems leadership:
- Old notions of leadership as dynamic, decisive, authoritarian and competitive are not well suited to complex environments
- System leadership requires well-developed skills of negotiation and consultation to enable collaborative direction-setting and decision-making with other stakeholders
- Good leadership is not only about the individual qualities of the leader but also about enabling the whole system to be supportive of innovation, an awareness and understanding of complexity and an appreciation of the perspectives of different stakeholders
- Successful leaders understand complex adaptive systems and culture

In summary he argued that transformational change across the public sector is no longer an option – and that new models of collaborative and shared systems of leadership, designed to promote and sustain joined up working to tackle complex health challenges, are urgently needed.

**Publications referred to in presentation:**


PANEL DISCUSSION: REFLECTIONS ON KEYNOTE PRESENTATIONS AND IMPLICATIONS FOR PRACTICE

Facilitated by Steve Park, Assistant Director of Policy and Communications, Newcastle City Council

Key issues discussed by the panel included:

- Challenges of balancing national and local priorities and of enabling participation and innovation against the backdrop of a performance management target-driven culture.
- The value of devolving responsibilities down to an area-level and of ensuring public participation and partnership approaches.
- Appreciating that ‘community’ is about people, not just place.
- Clarifying the relationship between Healthy City partnerships and Health and Wellbeing and other high-level partnership boards.
- The importance of developing a convincing narrative that tells a coherent and comprehensible story – that resonates with and makes sense to people.
- The importance of Healthy City Co-ordinators as ‘boundary spanners’.
- The digitalisation of relationships and the role of new technologies in helping us keep up with trends and tackle wicked problems (e.g. Shisha).
- Appreciating that many individuals and communities do not have choices.
- The importance of recognising that critics have used the ‘nanny state’ argument over many decades – to resist legislation and regulation in areas such as clean water, seat belts and tobacco.
- How do we use local systems and the wider Healthy Cities Network and movement to address and govern risk conditions such as the commercial determinants (potential role of Politicians’ Group)?
- The potential value of drawing on and utilising Health 2020.

ROUND TABLE DISCUSSIONS

Helen Wilding introduced the round table discussions, drawing on Prof. Ilona Kickbusch’s presentation ‘21st century Healthy Cities Leadership’ (available in both PowerPoint and Video formats), delivered at the 2013 WHO Healthy Cities Business Meeting in Izmir.

Key points emerging from the discussions included:

**Group 1:**

*Question 1 – How far have cities/towns and Health and Wellbeing Boards come in developing leadership & governance for health and wellbeing?*

- Different for Unitary and District Councils
- Examples of working together across districts
- Where there are interim steps affecting governance, how do you ensure feed in to different levels and overcome challenges of disconnectivity
- Examples of partnership board memberships given e.g. children, mental health
- How far can local authorities push governance locally, where national governments won’t take it on?
- Some good government development around things that Health and Wellbeing can govern but massive areas that we have no governance over
- Can we govern who goes into schools and promotes what, for example?
- Example of joint working on initiatives such as sunbed outlet licensing in Liverpool
- Important to take wider and involve every department and organisation in the discussion /debate
- Involvement of planning applications and how to manage investment into the city issues.

Importance of tying up agendas to givern issues. Need to sort out silos
- Tobacco issues to learn from
- No models for what inclusion of a fast food outlet in a given area will do to the health of the area
- Need to invest in developing models around saturation point for fast food takeaways as with alcohol

**Question 2 – What works well and what doesn’t work well?**

**Works Well**
- CIPs around alcohol
- Commitment to joint working on H&W Boards
- Free school meals and cooking being introduced into schools
- Health and Safety legislation for workplaces. Not considered as Nanny State but in relation to things like MUP, standardised packaging etc. These thing are, and are seen as, bad
- Public Health in Local Authorities opens ip opportunities for increasing local governance. Need to extend this
- Links between LA and CCG on Health and Wellbeing Boards
- Recognition of need for health literacy in population
- Lead politicians for key public health issues. Provide a focal point for media and promotion of messages
- Sharing good examples from elsewhere through network members feeding in to local groups and Health and Wellbeing Boards

**Not so Well**
- Planning regulations that allow any business to open up and stop councils denying planning unless CIP for Alcohol
- Making a case for prevention in hospital sector
- Modelling of impact around health
- Reliance on the creation of work and jobs as a measure of improvement
- Linking wider determinants and causes of the causes to health outcomes
- Political decisions by governments to take decisions that didn’t take account of health impacts
- Engagement of public in health and wellbeing boards
- Thin expectations from public around health care and not around prevention
- Understanding complexity of issues involving wider determinants
- Role of planning in health and prevention
- Understanding behaviour change

**Question 3 – What can the Network do?**
- Develop briefings around causal chain for Health and Wellbeing Boards
- Collective cities through network to come together to lobby on key issues such as sugar consumption, MUP, fast food availability, etc.
- Use network much more via forum to link on lobbying issues and actions that can be taken
- Highlight discrepancies in funding across the country
- Extending advocacy toolkit from tobacco into other areas of health impacts
- Simplification of messages for Health and Wellbeing Boards and public
- Shared voice for difficult agendas
- Develop briefings on governance of health issues within the membership for Health and Wellbeing Boards
- Recognising reality of what we can do and can’t do
- Understanding regulatory powers of local authority and consider how these could be connected to prevent things falling through the gaps for the improved health of the population. Understanding what is legal and what isn’t
- Understanding the role of social media in improving health and wellbeing. How it can impact on loneliness or health management
- Work on developing links with Scotland and Wales
- Use PHE monies to develop a model of extending governance locally and opportunities for lobbying national bodies/government
- Develop links with LGA
• Make the most of opportunities to promote work of individual cities through the forum and meetings

Group 2:

Question 1 – How far have cities/towns and Health and Wellbeing Boards come in developing leadership & governance for health and wellbeing?

Preston:
• Challenge with 2 tier local authority
• Board at County Council level with 12 districts and 6 CCGs - substructure of health and wellbeing partnerships developed at district level with no mandate locally or decision making powers
• Current review of Health and Wellbeing Board – changes to governance arrangements likely in next 12 months

Wakefield:
• Health and Wellbeing Relationships are stronger. Lack of direction at start but impacts are now being seen
• Using tools such as Health Impact Assessments to help start discussions
• Engagement programme – difficult to engage those that don't want to
• Using development sessions to increase understanding

Belfast:
• Public Health and Health inequalities are separated (PH agency)
• Strategic Partnerships – Councils see themselves as leaders
• Have two healthy cities which are very influential

Wales:
• Councils and Health Board had joint statutory responsibilities with joint strategy
• Years of relationship building
• Now local service Board deals with all issues not just health and wellbeing
• Partnership with Marmot team has been very influential and useful in Swansea (same felt in Lancashire, also Marmot pilot). Whole integrated plan based around reducing health inequalities

Newcastle:
• History of Healthy Cities Partnership and LSPs

Question 2 – What works well and what doesn’t work well?

• Benefit of Healthy Cities:
  o provides sharing platform
  o Relationship building between agencies
  o From two tier perspective: getting city and lead politician to come together to work on common agendas

• What hasn’t worked:
  o Tension with PH going into local authorities. Multiple competing perspectives
  o Issues around ring fenced PH grant coming to an end and how to use this post 2015

Question 3 – What can the Network do?

• There was talk at EU level of having set pack / toolkit to deliver to elected members
• Need for template on settings based approach to be used by cities
• Public health’s use of ‘wellbeing’: Healthy Cities is all about salutogenesis – risk of going back to disease mode. Need to go back to basics as the UKHCN and look at what's our understanding of
health/wellbeing etc. to ensure consistency of message and shared understanding. PHE money could be used for this

*Action: UK Network to develop standardised toolkit*

**Group 3**

**Question 1 – How far have cities/towns and Health and Wellbeing Boards come in developing leadership & governance for health and wellbeing? &**

**Question 2 – What works well and what doesn’t work well?**

**Swansea:**
- Need better coordination between local services boards (at an area level) and health boards at a much broader level
- Have paid community connectors in place to build resilience
- The work with GPs in getting them engaged with the bigger picture – matching their agendas with strategic health priorities has been positive
- Messages such as step outside for your cigarettes has been very positive and successful because it has had an integrated approach

**Manchester:**
- Leadership and communications are key
- ‘Issues’ often engulf the broader debate and these are usually health and social care focussed
- There is a tension between structure and freedom to innovate
- Balance evidence based and informed policies
- Obesity is a big issue – and the Board are looking for stats on how things will change immediately – which is not realistic for most health challenges
- Need to make sure that we don’t lose out on research as this isn’t being prioritised

**Newcastle:**
- Need to give more ‘clout’ to community leadership – people are the experts in their medical care
- The variation of Boards across the country – how does this impact on how inclusive and effective they are?
- Now have moved Age Friendly Cities and Healthy Cities to the chief executives portfolio – should make it more connected
- Officers under cuts are losing so much capacity that it makes it hard to drive anything that isn’t business as usual forward politically
- PH has moved into the local authority at such a time as to weaken the potential impact due to the austerity

**Sunderland:**
- Need a balance between the how we do things (the strategy) and what we do (the services) – the hard thing is to show the relationships
- Health champions – training frontline workers and elected members in key health issues
- The GP – elected member relationships that have developed through the HWBB have been really positive
- PH budgets are being used to fund council services eg parks and open spaces – need to be clear on the PH benefits of doing this

**East Staffordshire:**
- Frustrations being a two-tier area as it is hard for messages to get in and out of the Health and Wellbeing Board
- Behaviours are key – need to be open and inclusive

**Preston**
- Have a healthy cities partnership but not clear on how this feeds into the HWBB at a county level
**Question 3 – What can the Network do?**

- Lobbying nationally on wicked issues
- Work with the LGA to market healthy cities - get the LGA backing
- Look at the themes members see as important
- Coordination and information sharing

**DISCUSSION AND PRIORITIES FOR FUTURE ACTION**

Those able to stay until the end of the session reflected on learning from the day and distilled key actions for the Network:

- **Lead Politicians’/Councillors’ Toolkit**: core principles, shared understanding; key lessons etc. [could form a ‘tailored’ section of Healthy Cities Toolkit below].
- **Healthy Cities Toolkit (particularly for New Members/ Starters)**: Healthy Cities movement; UK Healthy Cities Network; core evidence; focus on wellbeing and salutogenesis/flourishing as well as governance of risk; Healthy Cities within context of ‘healthy settings’; use of video clips/talking heads from co-ordinators, politicians, funders, other stakeholders [N.B. check whether WHO is producing anything for Phase VI].
- **Summary Publications**: value of distilling core elements of ‘dense’ publications such as those referred to in the morning presentations – loads of great material but really hard to digest!
- **Training in Leadership and Governance**: potential for new host/co-ordinating team to commission tailored training for Network members – possibly drawing on Durham University’s existing course.
- **Core Cities**: value of retaining and strengthening links – both at city level and through Network representation on sub-group.
- **Future Development of Network**: value of new host/co-ordinating team commissioning work to explore possible models for the future (e.g. community interest company) and clarifying benefits of each in terms of opening up funding and other opportunities.
- **Politicians’ Group**: the group agreed at its meeting to prioritise development and advocacy around a few issues – value of the group focusing on this (supported by the new host/co-ordinating team) in the run-up to the General Election.
- **Building Links with Key Organisations**: value of strengthening links with organisations such as the Local Government Association (and equivalents in Scotland, Wales and Northern Ireland) and the UK Faculty of Public Health – and of harnessing the energy and enthusiasm of passionate individuals within them.
PARTICIPANTS

Present:
Speaker – Dominic Harrison, Blackburn with Darwen
Speaker – David Hunter, Durham University
Facilitator – Steve Park, Assistant Director or Policy & Communications, Newcastle
Chair – Eugene Milne, Director of Public Health, Newcastle
Cllr Lorraine Beavers, Lancashire County Council
Cllr Mark Child, City and County of Swansea
Dr Sandra Davies, Liverpool City Council
Emma Dixon, Carlisle City Council
Prof Mark Dooris, UCLan
Barbara Drummond, Public Health Manchester
Cllr Pat Garbutt, Wakefield
Cllr Roy Gladden, Liverpool City Council
Karen Graham, Sunderland City Council
Michelle Halfpenny, Stoke on Trent City Council
Stephen Hewitt, Bristol City Council
Russell Jones, Glasgow Centre for Population Health
Rob Newton, Leeds City Council | Leeds Metropolitan University
Sharon Miller, ABM University Health Board, Swansea
Jonna Monaghan, Belfast Healthy Cities
Jenny Paul, Lancashire County Council
Cllr Bernard Peters, East Staffordshire Borough Council
Liz Robinson, Newcastle
Cllr Ann Schofield, Newcastle
Chris Shaw, Sheffield City Council
Gulab Singh, Lancashire County Council
Cllr Melville Speding, Sunderland City Council
Paul Staines, Newcastle
Charlotte Taylor, East Staffordshire Borough Council
John Wilcox, Wakefield Council
Helen Wilding, Newcastle City Council

Apologies:
Dr Muna Abdel Aziz, Warrington Borough Council
Annie Alexander, NHS Brighton and Hove
Cllr Eunice Campbell, Nottingham City Council
Simon Clarke
Jonathon Fagge, Norwich City Council
Lisa Gibson, the Leeds Initiative
Cllr Gwen Hassall, Stoke on Trent City Council
Cllr Mike Jones, Brighton and Hove City Council
Sharan Jones, Nottingham City Council
Sal Khan, East Staffordshire Borough Council
Cllr Adrian Knapper, Stoke on Trent City Council
Judy Kurth, Stoke on Trent City Council
Cllr Mary Lea, Sheffield City Council
Hira Miah, Lancashire County Council
Cllr Moore
Cllr Lisa Mulherin, Leeds City Council
Eamon O’Kane, Derry Healthy Cities
Cllr Pervez, Stoke-on-Trent City Council
Rimple Poonia, Portsmouth City Council
Paul Southon, Sandwell MBC
Cllr John Swindells, Preston City Council
Susan Toner, Public Health Wales