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bulletin

Public health and local government

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Introduction

For the first time since 1974, responsibility for improving public health is returning to local government. Public health has historically been based in local authorities; however in 1974 a local government reorganisation placed public health within the NHS[1]. The term 'public health' is widely defined as 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society' as coined by Sir Donald Acheson in his 1988 inquiry into public health in England[2]. The Department of Health describes 'public health' as work which promotes healthy lifestyles and helps people to avoid becoming ill[3], unlike 'clinical healthcare' which largely concerns diagnosis and treatment of illness.

The current reforms which return public health to local government have been said to be part of the most radical restructuring of the NHS since its formation in 1948[4]. The enormous changes which the restructuring involves, as well as the social and political changes since 1974, mean that comparing the new role of local authorities in public health to the pre-1974 structures may not be especially helpful[5]. Consequently, local authorities are now facing a considerable challenge in developing new management structures and exploring how to use their new responsibilities most effectively. This Bulletin will therefore explore:

- the emerging national level policy context around public health and local government;
- what local government needs to do to respond to the emerging public health legislation;
- why it is important to join up public health and the activities of local government;
- some of the key challenges facing local government associated with the public health reforms.

The emerging national level policy context

The Health and Social Care Act[6], which gained Royal Assent on 27 March 2012, has led to a series of fundamental changes affecting the national and local management of public health services. The Government states that the Act aims to improve the quality and efficiency of the organisations which commission, regulate and support public health services. The Act aims to[7]:

- improve the quality and choice of healthcare for patients and increase transparency for taxpayers;
- make GPs and other clinicians the primary commissioners of healthcare services;
- create a more coherent system for regulating providers;
- limit the ability of Ministers to politically micro manage while still remaining accountable;
- streamline arms length bodies and remove unnecessary tiers of management.

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[1] Baggott, R. (2000) *Public Health: Policy and Politics*. Basingstoke: Pagrave MacMillan
[2] NHS Herefordshire http://www.hertfordshire.nhs.uk/what-we-do/the-nhs-and-you/public-health.html
[3] Department of Health http://www.dh.gov.uk/health/category/policy-areas/public-health/
[4] Campbell, D. (2011) *NHS Reforms: What Will Happen and Why?* The Guardian
[5] Madelin, T. (2011) Transfer of local public health functions from the NHS to local authorities, *The Lancet, UK Policy Matters*
[6] Health and Social Care Act 2012, available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[7] Department for Health (2012) *Factsheet A1: The Health and Social Care Act 2012*. Available at www.dh.gov.uk/healthandsocialcarebill

At the national level, the Act will lead to the creation of the following new structures:

- **Public Health England –** a new national body which will deliver specialist public health services and advice to national and local government as well as coordinating nationwide health protection work, such as vaccination programmes. It will also assist the development of national public health campaigns;
- **Healthwatch England –** this will be an independent body which champions consumer interests related to health and social care in England by gathering data and representing the views of the general public and patients. This body replaces LINks;
- **NHS Commissioning Board –** established as an independent body. At arm's length from the Government, the NHS Commissioning Board currently supports the development of Clinical Commissioning Groups and, following April 2013, will be responsible for allocating resources across the NHS and commissioning certain services, including GP practices.

The legislative elements of the Health and Social Care Act are framed in a number of pieces of policy documentation which have emerged over the course of the last three years. Integral to the development of policy has been the recognition of the importance of local government in the public health agenda and twinning addressing public health with other economic and social challenges.

The Government's 2010 White Paper 'Healthy Lives, Healthy People'[8] presents a new vision for public health in which people live longer, healthier lives; and the health inequalities between rich and poor are reduced. The White Paper presents the new role of local government in improving public health. The expression 'improving public health' refers to a wide range of activities that aim to improve health and reduce health inequalities by influencing the broader determinants of health[9]. A subsequent White Paper 'Caring for our future: reforming care and support'[10], published in July 2012, emphasises local government's new role in promoting health and wellbeing, and giving more control to citizens to improve their health situation.

The emerging responsibilities of local government

At the local level, the Act formalises the decommissioning of several existing public health organisations and relevant structures, including:

- Primary Care Trusts;
- Strategic Health Authorities;
- Local Area Agreements;
- Local Involvement Networks (LINks);
- Health Improvement Partnerships.

These structures and functions will be replaced, and by April 2013 the following changes are expected to have been made:

- **Local Authorities –** local authorities will have a new role in commissioning care and support services, and protecting and improving health and wellbeing. They are expected to use their knowledge of their communities and work together with health and care providers, community groups, and other agencies to tackle local public health challenges;
- **Director of Public Health –** a Director of Public Health will be employed by local authorities but appointed in coordination with Public Health England. The Director will be the principal adviser on health for elected members and officials, and will be charged with delivering key new public health functions;
- **Clinical Commissioning Groups (CCGs) –** CCGs will consist of GP's, other health professionals and lay members who will be responsible for commissioning services for their local community from any service provider which meets NHS standards and costs. They are expected to work with local organisations and partners to design services which meet the needs of the local population;

[8] Department of Health, (2010). *White paper. Healthy Lives, Healthy People: Our strategy for public health in England,* Available from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf
[9] Faculty of Public Health (2006) Public Health: Specialise in the bigger picture. Available at http://www.fph.org.uk/uploads/ph_careers_booklet.pdf
[10] Department of Health, (2012), *Caring for our future: reforming care and support*. Available at http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

- **Health and Wellbeing Boards –** Health and Wellbeing Boards are being created to bring together local commissioners across the NHS, public health and social care, elected representatives, and representatives of Healthwatch. The boards will set the local framework for commissioning of healthcare, social care and public health services, and work with commissioning groups to develop Joint Strategic Needs Assessments (JSNAs) and joint health and wellbeing strategies for their area;
- **Local Healthwatch –** this will replace LINks to be the new principle consumer voice at the local level for people who use and need public health and social care services.

Under the reforms, local government will work on all three key domains of public health: health improvement; health protection; and health services. In addition to having a general duty to improve local public health, local authorities will take on specific responsibilities for commissioning a list of services, some of which (such as initiatives to tackle smoking, alcohol and drug misuse, obesity, increase physical activity and improve nutrition) are already part of local authorities' work, while others (such as the NHS Health Check programme) will be less familiar[11]. Some responsibilities will be mandatory, including[12]:

- appropriate access to sexual health services;
- ensuring there are plans in place to protect the health of the population, including immunisation and screening plans;
- ensuring NHS Commissioners receive the public health advice they need;
- the National Child Measurement Programme (NCMP);
- NHS Health Check assessment.

Other services will be at the discretion of local authorities, depending on national and local priorities.

Why local government and public health?

The changes brought in by the Health and Social Care Act mean that local government will now be responsible for local health improvement functions, and will be given a ring-fenced budget to deliver them. The reasoning for returning public health responsibilities to local government has been outlined in the 2010 Marmot Review[13] 'Fair Society Healthy Lives'. The Marmot Review found that factors such as education, employment, environment, transport, planning, housing, and leisure services, are a crucial determinant of people's life expectancy, and their physical and mental wellbeing[14]. These wider social factors generally lie outside of the NHS remit and fit more closely with the work of local authorities, thus it may seem logical to move public health responsibilities into local government.

Historically, research has found that the most significant improvements to life expectancy have not been achieved through health services but through public health interventions[15]. Furthermore, according to McKeown, curative medical measures have only played a small role in declining death rates[16]. Since local government's work affects community health and wellbeing and is directly accountable to citizens, it seems appropriate that local government is given responsibility to address local health inequalities. It can be argued that public health depends upon the efforts of an organised society, thus local government's role in governing society means it is well placed to have a strategic role in public health improvement. Furthermore, in line with the Government's localism agenda, placing public health back in the remit of local authorities focuses on the needs to develop place specific approaches to public health. The reforms give new power to individuals and organisations at the local level and aim to encourage individuals, communities and local organisations to address their own particular health needs and those of their communities.

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[11] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 2*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

[12] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 2*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

[13] Marmot, M. (2010) *Fair Society Healthy Lives - The National Strategic Review of Health Inequalities*. Available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[14] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 3*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

[15] Department of Health, (2010). *White paper. Healthy Lives, Healthy People: Our strategy for public health in England,* Available from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf

[16] McKeown, T. (1976). *The Modern Rise Of Population*. London: Edward Arnold, Cited in: Madelin, T. (2011) Transfer of local public health functions from the NHS to local authorities, *The Lancet, UK Policy Matters*

Following the approach taken by the Marmot Review, the public health reforms place greater emphasis on creating conditions for people to take responsibility for their own lives[17].

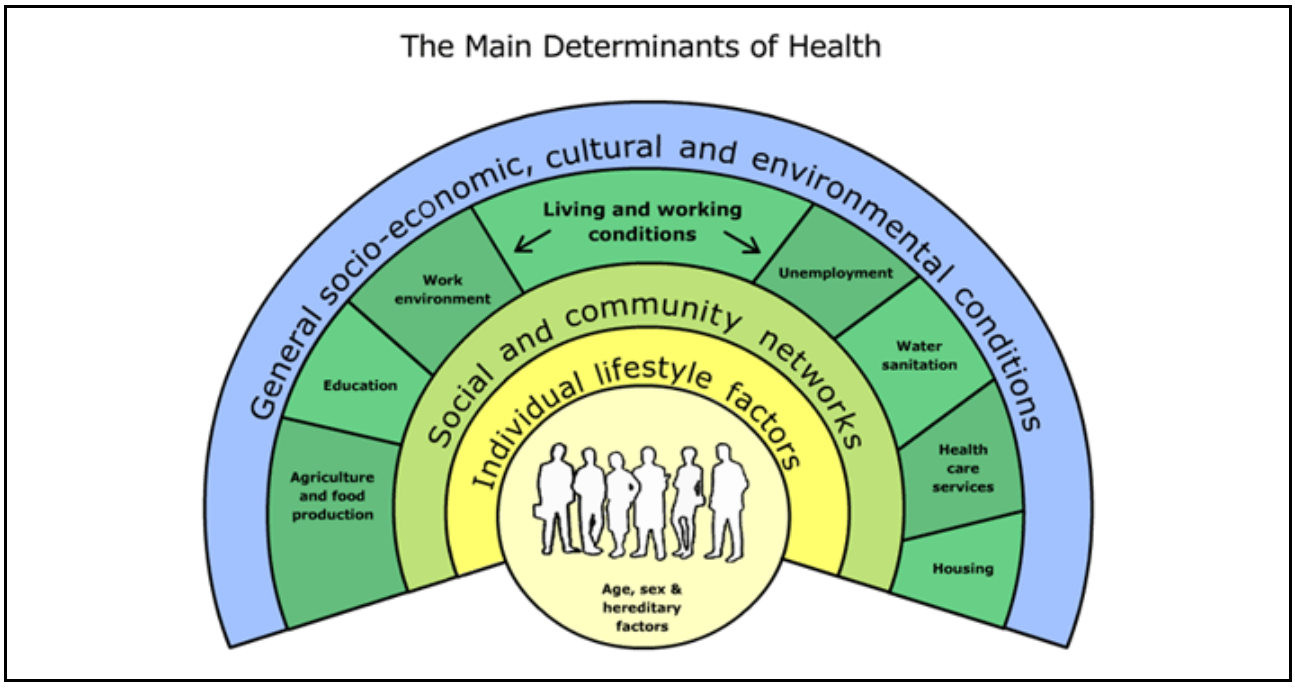
Overall, local authorities are considered to be well placed to take a broad view of which services will promote public health effectively, and to combine traditional public health initiatives with other local initiatives aimed at addressing wider public health issues. According to the Department of Health, responsibility for improving public health has been returned to local government for several reasons[18]:

- **population focus –** local authorities are democratically accountable to their local populations and naturally have a local population focus to their work;
- **ability to shape services to meet local needs –** local political leadership is critical to creating the powerful coalitions necessary for promoting health and wellbeing, and local authorities hold many of the levers for shaping local action on public health;
- **ability to influence wider social determinants of health –** local authorities work directly on the social, economic and environmental factors which have been found to strongly influence public health;
- **ability to tackle health inequalities –** local authorities have detailed knowledge of the health inequalities in their area and can use existing partnerships to reduce these inequalities.

Joining up public health and local government

Figure 1 by Dahlgren and Whitehead[19] illustrates the range of factors which are thought to influence public health.

Figure 1: The main determinants of health

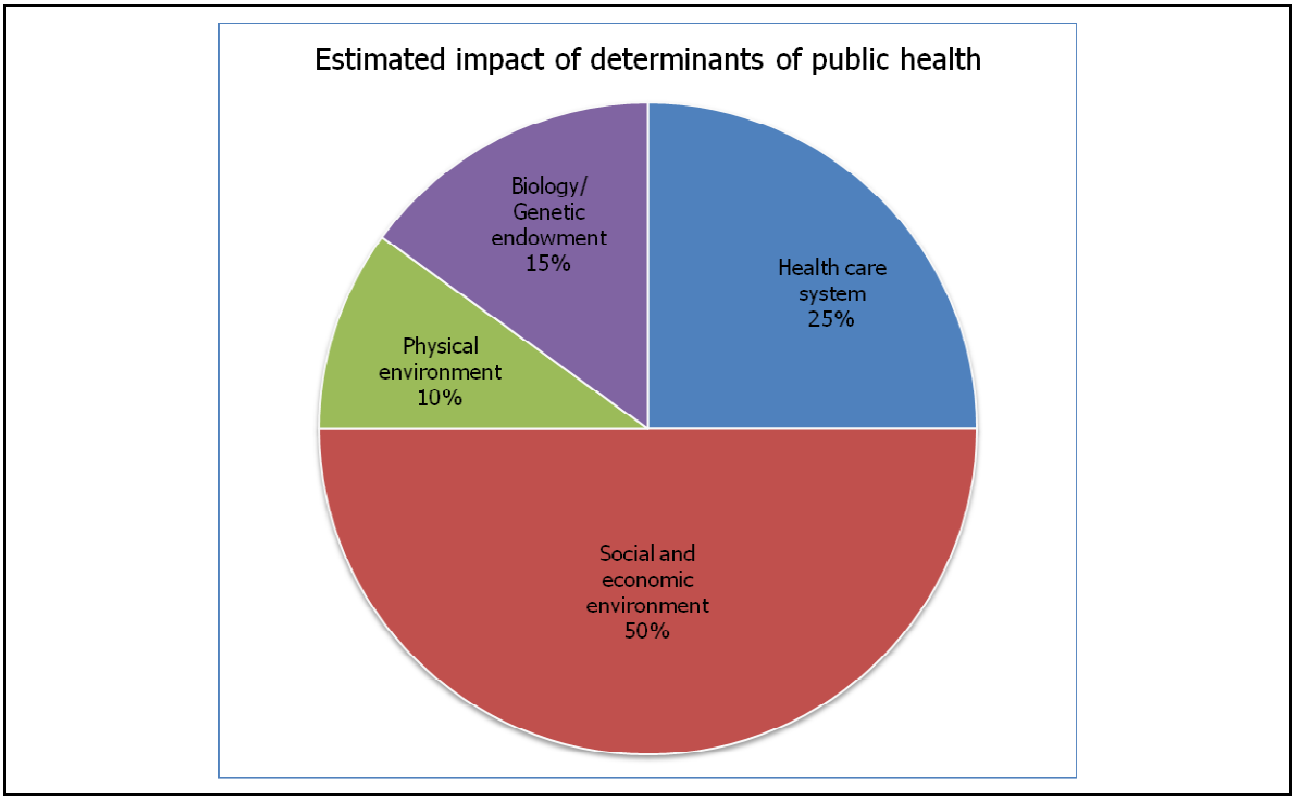


[17] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 2*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE
[18] Department of Health (2011) *Public Health in Local Government: Fact sheets*
[19] Dahlgren, G. and Whitehead, M. (1991), *Policies and strategies to promote social equity in health*, Stockholm: Institute of Futures Studies, Available at healthypeople2010.wordpress.com

Figure 1 shows four layers of determinants which influence a person's health. At the centre are biological factors which are specific to individuals, such as age, sex and genetic endowment. The second layer of factors comprises individual lifestyle choices, such as use of intoxicants, diet and physical exercise. The third level comprises social and community networks; this includes a person's social relations, lifestyle norms within their community, and informal and formal community support. The outer layer consists of overarching socio-economic, cultural and environmental factors, such as housing, work environment, healthcare services, and water sanitation.

All of these factors influence public health but some are estimated to be more important than others. Figure 2 shows that healthcare services are only estimated to contribute up to 25% of a population's health status, while social, economic and environmental factors are estimated to contribute up to 50%.

Figure 2: Estimated impact of determinants of public health[20]



While in general people are living longer, there is significant variation in people's health and wellbeing across England, and the lower a person's social position, the worse their health is likely to be[21]. The Marmot Review highlights that there is a difference of seven years between life expectancy in the poorest and richest neighbourhoods[22]. This inequality in health is widely recognised to be caused by socio-economic inequalities and these are often deeply inter-related. The Marmot Review describes the need to reduce health inequalities as 'a matter of social and economic justice', and states that this can only be achieved if local delivery systems are effective and if health equality is included in all policies[23]. There are therefore a great number of socio-economic factors which local authorities can address to target local health inequalities, a number of which are discussed overleaf.

[20] Canadian Institute of Advanced Research, Health Canada, Population and Public Health Branch. AB/NWT 2002
[21] Department of Health, (2010). *White paper. Healthy Lives, Healthy People: Our strategy for public health in England,* Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf
[22] Marmot, M. (2010) *Fair Society Healthy Lives - The National Strategic Review of Health Inequalities*. Available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[23] Marmot, M. (2010) *Fair Society Healthy Lives - The National Strategic Review of Health Inequalities*. Available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

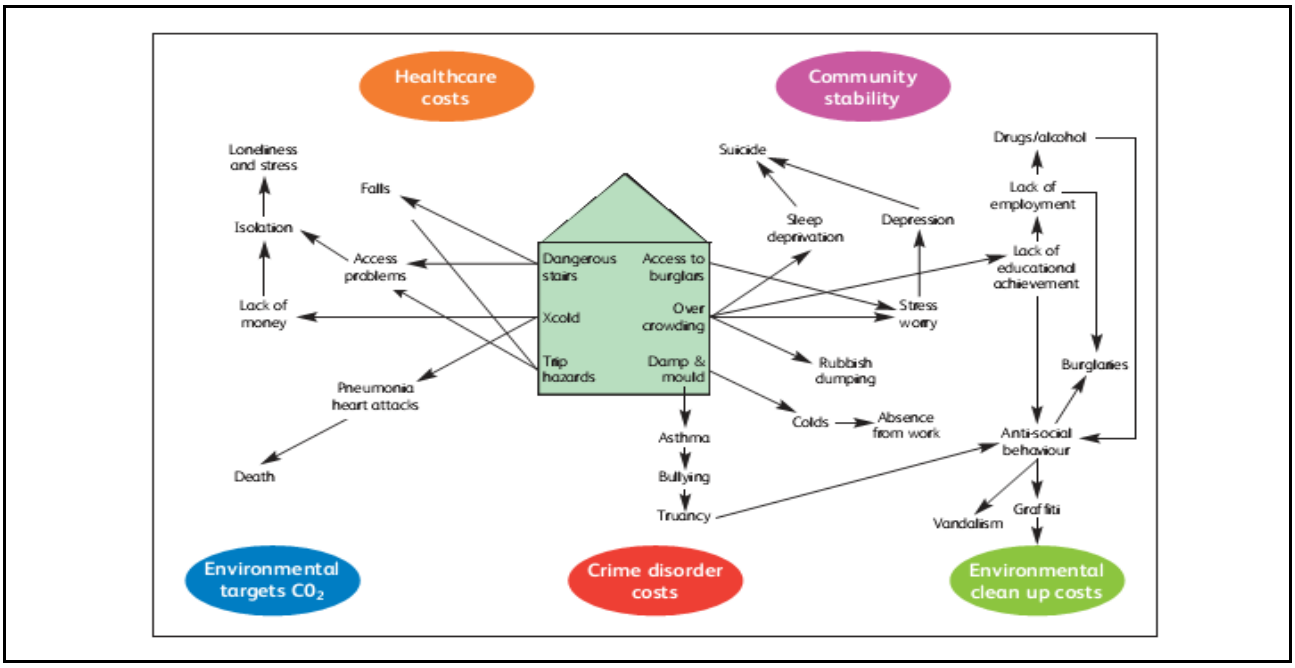
Employment and skills

Local economy and local public health are strongly inter-related for a number of reasons, including mental ill health caused by unemployment, low productivity due to ill health, and low income being strongly associated with obesity, smoking and poor living conditions. Improving mental health is found to be especially important for reducing unemployment (e.g. it was found that 9.8 million working days were lost in Britain in 2009/10 due to work related stress, depression or anxiety alone)[24]. Initiatives which promote greater physical and mental health can lead to a more productive local workforce which could boost the local economy and improve the life chances of the individuals concerned.

Housing

Figure 3 illustrates how problems with housing, such as insufficient heating, overcrowding and damp can lead to a wide range of healthcare needs, as well as wider social problems.

Figure 3: Repercussions of poor housing[25]



Cold homes are linked to an increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poor mental health[26]; and those who spend longer at home, such as elderly people and people with a disability, are disproportionately affected. Cold housing may be due to structural problems with buildings or an inability to pay for heating. Fuel poverty has received a lot of attention recently, as energy costs continue to rise and many households are struggling financially due to the recession. The highest proportion of non-decent housing is estimated to be found in the private rental sector, where incentives for landlords and tenants to improve their homes are often lacking.

Transport and planning

Planning for better public health concerns the affect which the physical environment and access to public transport has on both physical and mental wellbeing. Communities which suffer from crowded surroundings, with high levels of traffic and few green spaces, are found to experience poorer health and more accidents[27]; and these are often the poorest communities. One initiative being used by a local authority to address public health and planning is NHS Bristol and Bristol City Council's Healthy Urban Team. The team contributes to pre-planning negotiations to raise public health issues and is essentially meant to 'health proof' the planning process [28].

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[24] Health and Safety Executive (2010) *Health and Safety Statistics 2009/10*, available at www.hse.gov.uk/

[25] Good Housing Leads to Good Health, CIEH 2008

[26] Housing Learning and Improvement Network (2011) *Briefing Paper Two, Public health and housing: We can get it right*

[27] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 3*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

[28] Bristol City Council (2011) *Active Bristol: Physical Activity Strategy 2011 – 2016*, available at http://www.bristol.gov.uk/sites/default/files/documents/health_and_adult_care/health_and_medical_advice/Bristol's%20Physical%20Activity%20Strategy.pdf

Arts and leisure

Arts and leisure services such as parks, leisure centres and museums are likely to promote better public health, either by facilitating physical activity or increasing mental and social wellbeing through art and cultural activities. Leisure and cultural facilities, such as libraries, are also often used for health education and resource provision since they are accessed by a broad cross section of society[29]. Ensuring that members of the population can afford to access arts and leisure services is important for addressing the health inequalities seen between poor and wealthy communities. One effective local authority initiative in this area was Blackburn with Darwen's 'Re:fresh programme' which provided free access to council leisure services. This programme contributed to a large increase in the number of people taking regular exercise, especially among groups which were the least active, including Asian women and people with a disability[30].

Regulatory services

Local authority regulatory services comprise a range of areas, including environmental health, trading standards and licensing. There are clear links between regulation and public health, especially regarding regulation of food, workplace and safety, tobacco, private sector housing, alcohol licensing, community safety, and air quality. A report[31] by the Department for Business, Innovation and Skills identified a range of benefits generated by regulation. Many of the benefits mentioned in the report have consequences for public health (e.g. improved security and public order can improve social and mental wellbeing; and protection of the natural environment can mean better air quality and green spaces for physical exercise).

A life course approach

The Marmot Review states that an effective way of improving public health and addressing health inequalities is to take a life course approach. This involves targeting public health interventions at the following stages: pre-natal; pre-school; school; training; employment; and retirement[32] (e.g. initiatives which promote breastfeeding may reduce infant mortality; and targeting the health of pre-school children can have important long term health consequences in terms of child development).

Furthermore, initiatives which address the needs of young people who are out of work, education and training (NEETs) can be important for young people's health (e.g. it has been found that young men who have been NEET for more than six months are three times more likely to have depression[33]). At the other end of the spectrum, the urgency to respond to the needs of the UK's ageing population is currently under the spotlight. Local authorities clearly have an important role in providing early intervention and prevention services to support older people to remain healthy and live independently.

Challenges of public health reform for local government

Whilst moving public health into local government may bring improvements, there are also some risks. Concerns have been raised over the possible increased politicisation of the public health environment and the loss of independence of the public health workforce[34]. Furthermore, some local authorities still have two tier structures, thus the public health teams could encounter difficulties working with partners who operate in both tiers[35]. In addition, a general risk is the uncertainty around the resources that will be available for public health and how they will be protected. Regardless of how efficiently the reforms are implemented, if sufficient resources are not available to local authorities, the effective delivery of any public health function will be reduced[36]. There are three particular challenges:

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[29] Improvement and Development Agency (2009) *Valuing Health: Developing a business case for health improvement*

[30] Blackburn with Darwen Borough Council http://refreshbwd.com/about-us/general-information.html

[31] Department for Business, Innovation and Skills (2009) *Better Regulation, Better Benefits: Getting the Balance Right*, available at http://www.berr.gov.uk/files/file53252.pdf

[32] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 3*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

[33] Local Government Association (2012) *From transition to transformation in public health, Resource Sheet 3*, Available at http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

[34] Faculty of Public Health, *UK Faculty of Public Health response to Healthy lives, healthy people: our strategy for public health in England response to the public health white paper*. Available at http://www.fph.org.uk/uploads/FPH%20response%20to%20Healthy%20Lives,%20Healthy%20People%20-%20Our%20strategy%20for%20public%20health%20in%20England%20-%20FINAL.pdf

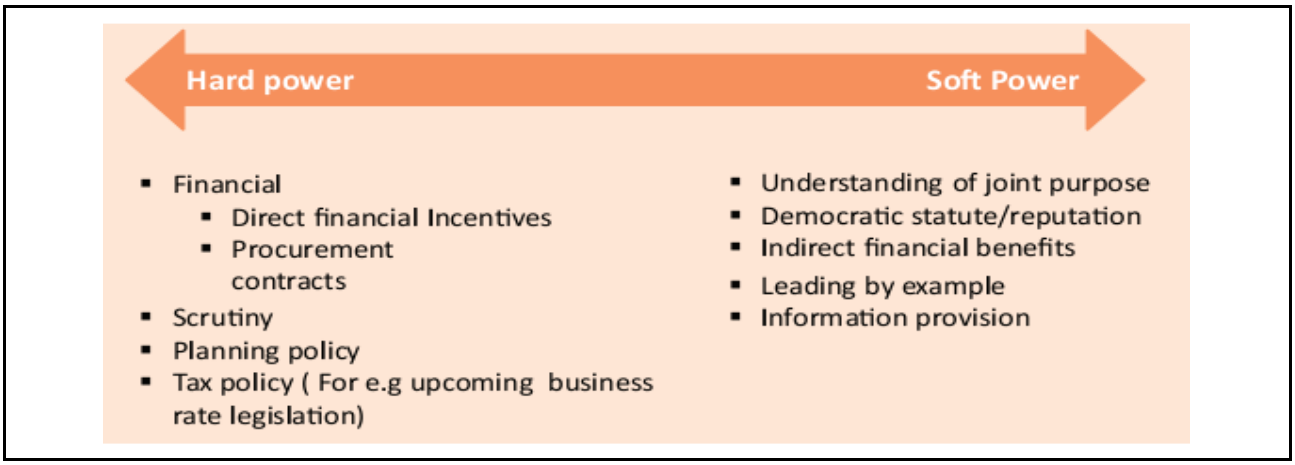
[35] Chartered Institute of Environmental Health response to the public health white paper http://www.cieh.org/uploadedFiles/Core/Policy/CIEH_consultation_responses/Response%20to%20the%20Public%20Health%20White

[36] Madelin, T. (2011) Transfer Of Local Public Health Functions From The NHS To Local Authorities, *The Lancet, Uk Policy Matters*

Governance

In order to drive public health improvement initiatives, local authorities will have to engage with internal as well as external stakeholders, many of which will only be able to influence indirectly. Developing bonded networks with shared risks and rewards is likely to be important, and the new Health and Wellbeing Boards (HWBs) will be important in creating these networks[37]. However, the duties passed to the HWBs do not necessarily come with additional powers for implementing their agenda. Figure 4 shows some of the levers available to local government representatives on HWBs, ranging from creating financial incentives to using softer powers of persuasion.

Figure 4: Levers available to local government representatives on Health and Wellbeing Boards[38]



The representatives on the HWBs should have a unique opportunity to redesign the local public health offer; however there are various factors which could hinder this opportunity. For two tier areas, the division of functions and leadership between districts and county councils may make it difficult to establish an inclusive and effective board membership, especially where there is a mismatch between administrative boundaries and the boundaries of service use[39]. Furthermore, differences in the structure of accountability and legitimacy of partners could also cause difficulties. While local government is accountable to local voters through the elected members, the health sector lines of accountability stretch back to the Secretary of State. These differences affect the organisational culture of decision making and may reduce the cohesion of HWBs[40].

Coordinating delivery

One of the central recommendations from the Marmot Review was to 'fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.'[41] This means that all parts of the council will need to consider their impact on local wellbeing and health. Local authorities will need considerable skill in coordinating all internal departments to respond to public health needs as well as working with agencies in the private and voluntary and community sector too.

In Lambeth, the Living Well Initiative is an example of a project which brings together organisations to develop an improved public health offer through a process of co-production. The project includes a new community options service, a new primary care support and enabling service, a new universal time banking service, and a new peer support service. During the project, it was realised that a key factor in achieving greater outcomes was the inclusion of citizens in commissioning and providing public services[42]. However, working to embed health improvement initiatives in the work of local government departments and other local public bodies could be problematic if councils do not have additional levers and powers. The New Local Government Network[43] suggests that a 'duty to cooperate', similar to the duty introduced in the 2011 Localism Act, could be important for giving local authorities a chance to deliver their new responsibilities effectively.

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[37] New Local Government Network (2012) *Healthy Places: Councils leading on public health*, Daria Kuznetsova, London:NLGN
[38] Extracted from: New Local Government Network (2012) *Healthy Places: Councils leading on public health*
[39] New Local Government Network (2012) *Healthy Places: Councils leading on public health*, Daria Kuznetsova, London:NLGN
[40] New Local Government Network (2012) *Healthy Places: Councils leading on public health*, Daria Kuznetsova, London:NLGN
[41] Marmot, M. (2010) *Fair Society Healthy Lives - The National Strategic Review of Health Inequalities*. Available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[42] New Local Government Network (2012) *Healthy Places: Councils leading on public health*, Daria Kuznetsova, London:NLGN
[43] New Local Government Network (2012) *Healthy Places: Councils leading on public health*, Daria Kuznetsova, London:NLGN

Public engagement

The transition of public health back to local government emphasises the importance of health services being accountable to local citizens. Local citizens and communities should have greater opportunities to become co-producers of public health improvements; however the best mechanisms for increasing citizen engagement in public health are not yet clear. HWBs will need to differentiate between ways of improving patient involvement (related to personal care and treatment) and ways to increase public involvement (related to strategic policy and service decisions)[44].

It is likely that to engage effectively with local people and hard to reach groups, local authorities will need to work very closely with the voluntary and community sector. The sector's contribution to community health and wellbeing is well understood, ranging from supporting patient advocacy and knowledge of local needs, to specific expertise from their role as a service provider. However, the heterogeneous nature of the voluntary and community sector may pose difficulties for local authorities in selecting representatives from this sector for HWBs[45]. Overall, if HWBs are to successfully fulfil their role, they will need a strategic approach to public involvement, and individuals will need to be empowered to actively co-produce and co-design public health services[46].

Concluding thoughts

The return of public health to local government places the wider determinants firmly under the spotlight. It represents a significant change in the way we think about health; moving from a focus on healthcare services, to a greater emphasis on the causes of public ill health and how these can be tackled for more sustainable, wider reaching outcomes. The Localism Act of 2011 has brought increased attention to the importance of identifying local issues and the potential for a range of local organisations to work collaboratively to produce local solutions. CLES welcomes this renewed focus on reducing local health inequalities and the new importance given to tackling the social, economic and environmental inequalities. There are however three key considerations which we believe should be integral to the accession of the powers associated with health reform:

- **a whole place approach –** the delivery of the health reforms should not just be about transfer of responsibility to local government, but instead to place. Effective change in public health can only be achieved through cross sector and cross departmental involvement;
- **outcomes based commissioning –** the commissioning associated with the CCG's must be undertaken on an outcomes basis and with key consideration of social value. This outcomes focused approach will ensure voluntary and community sector involvement, and that commissioning is undertaken with community need at the forefront;
- **economic and social linkages –** public health reform must sit across the wider challenges facing local government and place, meaning it must recognise the challenges facing place around economy, worklessness, skills and other factors, and respond in a joined up way.

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[44] Litva et al (2002) *The public is too subjective': public involvement at different levels of health-care decision making*
[45] Humphries et al (2012) Health and Wellbeing Boards: System leaders or talking shops
[46] New Local Government Network (2012) *Healthy Places: Councils leading on public health*, Daria Kuznetsova, London:NLGN