Putting ‘the public’ back into public health
A national conference on building the voice of citizens into public health evidence

Post-Conference Briefing

On 16th January, Health Together, part of Leeds Beckett University's Institute for Health and Wellbeing, successfully hosted a conference entitled 'Putting the Public Back into Public Health'. The event brought together 163 delegates from a wide variety of backgrounds and organisations. These included 16 different universities, 15 local authorities (some attendees were elected members), 11 NHS bodies (including 3 Clinical Commissioning Groups (CCGs) and one Commissioning Support Unit (CSU), 23 voluntary sector organisations including national, regional and local bodies, 14 national agencies and 5 consultancies.

The conference featured keynote talks from Professor Mike Kelly, Director of the Centre for Public Health Excellence at NICE, David Hunter, Professor of Health Policy and Management at Durham University and Alison Hill, Deputy Chief Knowledge Officer at Public Health England. Professor Jane South from the Institute for Health and Wellbeing delivered a joint talk with Gohar Almas Khan, a volunteer health champion from South Leeds Community Alliance. The event was jointly chaired by Councillor Lisa Mulherin, Chair of Leeds Health and Wellbeing Board, and Leeds Beckett University's Visiting Professor, Mark Gamsu.

A summary of the conference including videos and keynote presentations can be found at:
http://www.leedsbeckett.ac.uk/healthtogether

Why building the voice of citizens into public health evidence is important

The starting point for the conference was the need for a rethink on evidence to give more prominence to citizens’ views and experiences. A workshop held the previous summer had discussed the rationale underpinning the conference and identified five reasons why this was an important issue (Box 1).

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<th>Box 1: Why building the voice of citizens into public health evidence is important</th>
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<td>1. To give a more complete picture to help local leaders make good decisions.</td>
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<td>2. To develop locally tailored solutions – whether at area, community or individual level.</td>
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<td>3. To enable a stronger focus on local innovation – having a pool of ideas, building on good practice and engaging the public in the planning and delivery of health improvement initiatives.</td>
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<td>4. To promote equity - using evidence gathered from those most affected by inequalities to promote social justice and close the health gap.</td>
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<td>5. To bring critical challenge as part of democratic processes.</td>
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Throughout the conference delegates were encouraged to discuss the following questions:

- What evidence is needed?
- What are the strengths and challenges in the way evidence is currently thought about and made available?
• Is the experience and voice of citizens included as part of evidence?
• What are the challenges to including citizen experience and voice? How can we address those challenges?

Seminars explored different perspectives on evidence:

• Clinical Commissioning Groups led by Alyson McGregor, Director, Altogether Better
• The Marmot Review led by Mike Grady, Marmot Review Team, UCL Institute of Health
• Health and wellbeing boards led by Liam Hughes, Chair of Oldham HWB and Councillor Mary Lea, portfolio lead for health and wellbeing in Sheffield
• Public Health led by Chris Bentley, Public Health Consultant
• Voluntary and community groups led by Hanif Malik, Chief Executive, Hamara Centre, Leeds
• Academic/research perspective led by Gemma Phillips and Mark Petticrew, London School of Hygiene and Tropical Medicine

Key themes from the conference seminars

*Changing perceptions of the value of community knowledge and action*

The most vital asset in any community is its people. People’s active involvement should be sought in co-designing services that are based on a more equal relationship between citizens and professionals. The goal is that people are recognised as experts by experience and become active partners in their care, but this requires widespread cultural change across different sectors.

*It is not a level playing field*

Evidence cannot be divorced from an understanding of inequalities and how they are perpetuated. Putting people’s lived experiences centre stage presents challenges to different professional power bases. There remains a need for wider political action on the determinants of health to address inequalities, because disadvantage and poverty continue to have such a fundamental impact on people’s lives.

*Involving not excluding*

Community engagement can and should be about reaching out to groups seldom heard and those with the greatest needs (see Box 2). Attention needs to be paid to those who don’t attend or access services and to those who are least confident to navigate systems. This could be supported through the involvement of advocates, health trainers and health champions.

**Box 2: Some categories of seldom-heard people** [Source: Professor Chris Bentley]

- **Hard to identify and contact** (e.g. rough sleepers, illegal immigrants)
- **Not available, no time** (e.g. people working long hours, carers)
- **Hard for public agencies to communicate with** (e.g. non-English speakers, people who are visually impaired)
- **Resistant to involvement with statutory bodies** (e.g. because they feel threatened, such as tenants in arrears)
- **Hard to engage on public bodies’ agendas**
- **Taken for granted.** Not hard to reach or engage with, but at risk of under-representation.
Research-based evidence is only part of the picture in local decision making

There is a need to gather a wide range of views across different groups and sections of society in order to develop practical solutions in local areas. Health and Wellbeing Boards (HWBs) have access to rich information from practice, but this can sometimes be at odds with what research shows. The key role of councillors as elected representatives needs to be acknowledged as they bring a unique perspective grounded in the realities of people’s lives, as do practitioners working with the public. More work is required to understand how local politicians view evidence and how they can be supported in using it effectively.

Different language, different worlds

There is not a good fit between academic research and the realities of the world of local government and there is no shared language around evidence. Research-based evidence is not that useful compared to local data and the knowledge that has been built up through years of local experience. Democratic accountability is also important.

Limited capacity for evidence gathering

There is a lack of research capacity in local organisations. In local government there is limited access to research funds to carry out locally relevant research and lack of capacity in terms of research skills. Voluntary and community sector organisations have to demonstrate their worth to funders, however, day-to-day pressures of delivery mean that there is little time for advocacy and influencing.

Research that is not relevant isn’t used

Research evidence needs to have relevance and applicability. It is vital to look at what type of research is needed and when. The dominance of quantitative research should be balanced with more qualitative research and action-oriented research to develop solutions. There is a need to develop a narrative that makes research-based evidence and public health analysis relevant for different audiences.

Taking a strategic approach

Health and Wellbeing Boards together with public services need to manage the complex relationship between public voice, practice and research-based information (see Figure 1). The Joint Strategic Needs Assessment (JSNA) is an obvious starting point; however the process needs to acknowledge the skills and life experiences that people bring to health. HWBs must advocate for people with reduced opportunities. Overall the approach should be to start where people are at, create the conditions to have conversations about the topics people want to work on, and then seek to build relationships over time. This then needs to be scaled up and implemented in a systematic manner across the public health system.

Figure 1: Sources of evidence
Future Considerations

This is a particularly challenging period of time with significant system change happening at a local level that is likely to have a major impact on the services that people receive and how they relate to them. We need a broader view of evidence across the system and most critically the involvement of citizens bringing local knowledge, understanding from experience and new ideas. This type of evidence can drive change, which in turn will lead to better outcomes for individuals and communities.

It is therefore crucial that we continue to build on the debate stimulated by the conference and emerging practice and move towards building the voice of citizens into evidence. There is scope for action at every level:

- At neighbourhood and GP practice level, where those delivering public health programmes in both statutory and third sector need to champion the voice of citizens as part of evidence. Participatory methods and/or asset mapping can be used to involve citizens as equal partners in deciding priorities and identifying actions.

- At local authority level with Health and Wellbeing Boards having the key leadership role. Some local authorities have established local commissions where the voice of the public and experiential knowledge of professionals is included as part of a strategic approach to assessing how health, social and economic issues are to be tackled.

- At CCG level (including CSUs), where commissioning decisions which include citizen voice need to be made in conjunction with local authorities. CCGs can consider how they promote volunteering at the interface between mainstream health services and the community.

- Across public health research, researchers need to work in partnership to meet stakeholder information needs and to gather evidence from those most affected by inequalities. New academic-community collaborations, such as community-campus partnerships, offer a vehicle for a two-way exchange of knowledge and expertise.

- At national and regional level, with Public Health England, NHS England and key voluntary organisations taking the lead at all levels within their structures. The National Institute for Health Research (NIHR) needs to consider how its processes can be modified to enable support for research which explores what citizens are contributing to public health.

Across the health system, there is potential to build a broader, more locally relevant, evidence base for public health. We do not have all the answers, but it is important to continue to debate the issues and to share ways of working which put the public at the centre of action on health.

This briefing was compiled by Jane South, Judy White and Mark Gamsu, Leeds Beckett University (formerly Leeds Metropolitan University). September 2014.

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