

**Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision**

**An innovation framework for public health commissioning**

**Research Report 6**

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Disclaimer

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# Abbreviations

ADPH Association of Directors of Public Health

BME Black and Minority Ethnic

BMER Black, Minority Ethnic and Refugee

CCG Clinical Commissioning Group

CE Chief Executive

CVD Cardiovascular disease

CVS Council for Voluntary Services

DH Department of Health

DPH Director of Public Health

GP General Practitioner

HIV Human Immunodeficiency Virus

HWB Health and Wellbeing Board

JSNA Joint Strategic Needs Assessment

LA Local Authority

LGA Local Government Association

LGBT Lesbian, Gay, Bisexual, Transgender

NHS National Health Service

NHSE National Health Service England

PH Public Health

PRP Policy Research Programme

PHE Public Health England

VCF Voluntary, Community and Faith

VCSE Voluntary, Community, Social Enterprise

WHO World Health Organization

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# Executive summary

## Background

This report is the sixth in a series of research reports arising from a Department of Health (DH) Policy Research Programme (PRP) - funded research project entitled *Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision*. The research project as a whole is designed to evaluate the impact of the public health reforms, with particular reference to the deployment of the ring-fenced public health budget, commissioning and providing preventive services and the new public health role of local authorities. The theme of innovation runs through the study as a whole and this report draws together innovation-related findings from six separate research activities, including national surveys, case study analysis and interviews. It interprets these findings in the context of three levers for innovation and across the spectrum of public health commissioning. It addresses key research questions of the study related to innovation in service provision, in the provider landscape, in targeting health inequalities and in community engagement and co-design. The report reflects broad definitions of ‘commissioning’ and ‘preventive services’, reflecting current realities of public sector commissioning for community wellbeing.

## Methods

Questions on innovation were included as part of the following project activities: (i) initial interviews with national stakeholders (n=11); (ii) national surveys (2) of Director of Public Health (DPH) and Clinical Commissioning Group (CCG) members of Health and Wellbeing Boards (HWBs) (2015 survey: n= 39; 2016 survey: n=35); (iii) a national survey of local Healthwatch and Voluntary, Community and Voluntary Sector (VCSE) members of HWBs (n=34); (iv) a national survey of VCSE sector organisations involved in health promotion and prevention (n=39); (v) interviews (n=90) carried out with stakeholders in ten case study sites across England which reflected geographical spread, different levels of disadvantage and different political control. Interviewees included the DPH, Chief Executive (CE), Service and Executive Directors, a CCG member of the HWB, HWB Chair, Health Scrutiny Committee Chair, NHS England member of the HWB, Healthwatch Chair and a representative from the Voluntary Community and Social Enterprise (VCSE) sector. Generalisation from our findings is limited given the small number of sites – ten out of a possible 152 local authorities - and low response rates for all four national surveys.

## Results

Results are presented for the following areas: definitions of innovation; levers for promoting and diffusing innovation; examples illustrating an innovation framework for public health commissioning; and the extent to which innovation is being encouraged since the public health reforms.

*Definitions of innovation*

While some interviewees and survey respondents refused to give a definition of innovation and/or rejected the concept of innovation in public health, considering the term over-used and a potential smokescreen for budget cuts, thematic analysis identified nine dimensions of innovation (in various permutations): something new; better outcomes; increased engagement and co-production; risk taking; collaborative action; understanding need; evidence of what works; leadership; and achieving more with less in the context of austerity. Analysis by site revealed differences in emphasis, in particular in the extent to which innovation in public health was explicitly promoted from member level through senior leadership and across all staff; in the role of evidence and implementation ‘at scale’, as opposed to experimentation and local knowledge; in communities as a source of innovation; and in the extent to which the VCSE sector was a partner in developing innovative projects. Interviewees also reflected on innovation arising from the location of public health teams in local authorities, less central control, more local flexibility, closer links with elected members and an increase in synergy across public health teams and local authority directors.

*Levers for promoting and diffusing innovation*

Interview data, including a range of examples, were mapped against three levers for innovation (downward, sideward and upward). Whilst this identified differences in distribution of the type of levers between case study sites, downward levers, such as leadership (within the local authority and across a whole system) and austerity predominated. Partnerships, alliances or networks (sideward levers) were a common trigger for innovation, although they were usually associated with sponsorship from political leaders. Many interviewees considered that health reforms had increased opportunities for partnership working, often focused on particular groups and communities of interest, identity or faith. However, these groups were less often mentioned as promoting innovation (though upward levers) than downward or sideward levers.

*An innovation framework for public health commissioning*

In addition to levers for innovation, eleven elements of an innovation framework for public health commissioning are illustrated by one or more detailed examples drawn from case studies and surveys. These encompass: (1) new approaches arising from additional responsibilities being taken on by public health teams (such as managing the social care fund); (2) public health skills in health needs assessments and data analysis contributing to targeting and mapping across directorates; (3) providing services through expanding the public health workforce, such as through using fire and rescue services for health promotion; (4) developing within and cross-directorate approaches for health improvement, including changes to school meals services, licensing, planning, housing and leisure; (5) system-wide approaches to public health challenges, such as child obesity; (6) programmes for recommissioning preventive services, including for drugs and alcohol, sexual health, wellbeing services and children’s services; (7) co-design of services for sexual health, drugs and alcohol, domestic violence and for Child and Adolescent Mental Health Services; (8) changes in the provider landscape, with greater involvement of the VCSE sector; (9) working with communities and developing community assets; (10) targeting inequalities in the context of the needs of underserved and vulnerable groups, including migrants, socially isolated people, lone parent families and children leaving care. Finally, and closely linked to commissioning preventive services, was a wide range of community-based projects which aligned with local government aims to increase community wellbeing. These ranged from general initiatives to promote healthy walks and use of green spaces, through family or community-based approaches, to specialised projects designed to promote skills and enjoyment whilst reducing social isolation

*How innovation is being encouraged and supported*

Whilst highlighting individual examples is useful for reflecting the range of initiatives, it does not indicate spread. A comparison of two national surveys of DsPH and CCG members of HWBs indicated that more respondents (86%) considered that local authorities encouraged innovation in 2016 than in 2015, especially in relation to cross-council working and integrated initiatives (79% and 76% respectively). VCSE organisations were more involved as providers (58% of respondents agreeing in 2016 compared with 39% in 2015), as were community groups (47% compared with 28%) and, in particular, a higher percentage of respondents identified an increase in uptake of services by underserved groups across the range of options, but especially as a result of community networks (50% compared with 29%), through the VCSE sector (55% compared with 31%) and neighbourhood venues (60% compared with 19%). Increased community participation, identified with encouraging innovation, was a key rationale for the reforms and, in 2016, a higher percentage of respondents considered this had been encouraged in relation to co-design of young people services (53% compared with 41%), identifying local public health priorities, (39% compared with 23%), influencing commissioning priorities (44% compared with 31%) and community capacity-building (53% compared with 36%). Moreover, healthy lifestyles were more likely to be considered across directorates (72% compared with 59%). Whilst response rates for both surveys were low and results need to be interpreted with caution, they support findings from case study sites.

## Conclusions

Innovation is subject to varied and discipline-specific definitions. In this report,we adopt a contextual approach, reflecting what interviewees and survey respondents considered innovative in their respective local contexts or organisations and have not sought to impose a single definition of innovation as a yardstick against which examples are to be judged. The report therefore reflects ambiguities associated with the term.

The distinct contribution of the public health reforms to innovation can be difficult to assess, given financial and other pressures to transform the public sector, which are ongoing, and the existence of innovative approaches which predated the reforms. Moreover, the parameters of what is included under the rubric of ‘innovation in public health commissioning’ are shifting in the context of commissioning for wellbeing in the public sector.

Co-location of public health teams, combined with a programme for recommissioning services funded through the ring-fenced public health grant in the light of local authority procurement procedures and priorities, have encouraged a combination of increased community involvement and co-production, connections across preventive and other local authority services, less emphasis on single interventions for unhealthy behaviours, greater recognition of the family and social context and the need to adapt good practice to local circumstances. Survey results indicate that for community involvement, co-commissioning and identification of underserved groups, there were changes in the direction anticipated by the public health reforms.

In addition to changes in traditional preventive services, there was also potential for innovation through public health perspectives being applied to traditional areas of concern for the local authority, new responsibilities for public health teams in areas such as leisure, and involvement across directorates, such as environment or planning, although public health involvement was less evident than in ‘people’ directorates.

It is clear from the nature of many public health challenges that a combination of the elements described in the public health commissioning framework is often required, to include community engagement, actions across the wider system and the choice of providers reflecting a more holistic and contextual approach.

Whether innovation is encouraged or implemented in practice partly depends on the existence of ‘levers’ promoting innovation and the extent to which these levers are aligned or are in opposition. While the framework provides an opportunity to reflect on patterns of public health innovation and change by authority, the analysis of downward, sideward and upward levers for innovation can help identify enabling factors and the sustainability of individual projects for each element of the framework.

The question remains over the extent to which the focus for innovation may change over time and whether the momentum for public health innovation is maintained as the changes instigated by the reforms become the norm.

# 1. Introduction

This report is the sixth in a series of research reports arising from a Department of Health (DH) Policy Research Programme (PRP) - funded research project entitled *Commissioning public health services: the impact of the health reforms on access, health inequalities and innovation in service provision*. The research project as a whole is designed to evaluate the impact of the public health reforms, with particular reference to the deployment of the ring-fenced public health budget, commissioning and providing preventive services and the new public health role of local authorities (<https://www.dur.ac.uk/public.health/projects/current/cphs/>).

The Public Health White Paper, *Healthy Lives, Healthy People: Our strategy for public health in England* (Secretary of State for Health, 2010) makes clear the extent to which the public health reforms were expected to result in innovation. Through the ‘radical shift’ represented by the reforms, local government and local communities would be placed ‘at the heart’ of improving health and wellbeing and there would be freedom to innovate in the ways that public health services were provided in the context of localism and local needs, rather than through central government performance management regimes. The White Paper adopted a lifecourse approach for improving health and tackling health inequalities (‘Starting well’, ‘Developing well’, ‘Living well’, ‘Working well’ and ‘Ageing well’). This was reflected in an emphasis on ‘key transitions’ and on the importance of not tackling individual risk factors in isolation. There was an emphasis on involving new partners, including charities, voluntary organisations and community groups, ‘as advocates for excluded groups and catalysts for action’ and on incentivising improved outcomes.

The theme of innovation therefore runs through the study as a whole and is particularly emphasised as one of the research questions addressed as part of workstream 2, that is, ‘Have new public health responsibilities led to innovation in the use of providers, in co-design, in targeting strategies and in models of provision?’ The research proposal identifies the following sub-questions:

* Has there been innovation in the provider landscape?
* Have services been delivered in innovative ways?
* Have lifestyle services been developed in innovative ways?
* Has the NHS Health Check/proactive case finding been delivered in innovative ways?
* Have services been targeted in new ways?
* Has there been an impact on health inequalities?
* Has co-design been promoted for older people/younger people?
* Has co-design led to innovation in service provision?
* Have community networks been used in innovative ways?

This report focuses on innovation in commissioning public health services with particular reference to these questions. It also explores innovation (including cross-sector approaches) in how preventive services are being provided, remodelled and targeted to improve health and reduce health inequalities and how local communities are being involved. Local authorities have the potential to address some of the social conditions and contexts which make it difficult to change behaviour and can exploit different environments in which support for adopting healthier lifestyles may be offered.

The reach of the reforms goes beyond simple remodelling of a limited set of traditional preventive services to encompass a greater public health focus on services traditionally commissioned or directly provided by local authorities and in strategy development across local authority directorates. Narrow definitions of either ‘commissioning’ or of ‘preventive services’ neither reflect the current realities of public sector commissioning nor the impact of the latter on promoting health and addressing health inequalities.

The report begins by exploring the concept of innovation and considers the relevance of the new organisational and decision-making context for public health within local government and the ways in which it has promoted new and sometimes unanticipated developments. The methods adopted across this study are set out, followed by the findings of primary research undertaken by the research team. In the review of results, we summarise ways in which innovation in public health was defined by survey respondents and interviewees, look at levers for promoting and diffusing innovative practice, illustrate the spectrum of public health commissioning through examples raised and review how innovation is being encouraged, supported or incentivised by local authorities. We conclude with a discussion of levers for innovation in the context of a public health commissioning framework.

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# 2. Exploring the concept of innovation

## 2.1 Innovation – what is it?

For local government, ‘Innovation is about improving the life of the people in our communities’ ([www.local.gov.uk/innovation](http://www.local.gov.uk/innovation%20%20%20) accessed 24.08.16). In the health sector, NHSE Chief Executive, Simon Stevens, has spoken of the need to ‘chart a new course’ and of the need for ‘unleashing innovation and improvement’ (Speech, 1 April 2014, [www.england.nhs.uk/2014/04/simon-stevens-speech/](http://www.england.nhs.uk/2014/04/simon-stevens-speech/) accessed 01.03.16). Innovation is widely seen as necessary, something to which all authorities and organisations should subscribe. However, it has many different definitions which, it is argued, align with the paradigms of respective disciplines (Baregheh, Rowley and Sambrook, 2009) and can be associated with many different types of change. It can, therefore, mean different things to different people, different things in different contexts and may require discipline-specific approaches.

In its national report, *Seeing the Light,* the Audit Commission (2007) noted that:

*When people talk about innovation they generally mean one of two things. A new product … is described as an innovation. But innovation is also the process by which organisations develop new products, services or ways of doing things* (p.13).

In the context of local government, the Commission defined the latter (the process by which organisations develop new products, services or ways of doing things) as:

*an approach to improvement with three defining features:*

* *Novelty – innovation introduces something new to the organisation, marking a break from its established practice.*
* *Influence on change – innovation results in an identifiable step change in the behaviour of the organisation.*
* *The goal of improvement – organisations innovate in order to deliver a performance improvement or increased value for money* (ibid.).

It further notes that, ‘The definition of novelty employed here recognises that innovation may involve adapting others’ existing ideas to an individual authority’s own circumstances … Innovation is therefore highly context-specific …’ (ibid.).

For the health sector, *Innovation Health and Wealth* (NHS, 2011) indicated that for the purpose of the review leading to its publication it had adopted the following definition of innovation:

*An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care where it is applied.*

(*Innovation Health and Wealth*, op. cit., p.9)

It went on to say that:

*Innovation has to be more than a simple improvement in performance, and to achieve its maximum added value to the NHS it needs to be replicable – and replicated – across similar settings. So innovation is as much about applying an idea, service or product in a new context, or in a new organisation, as it is about creating something entirely new ... Innovation is not just about the originating idea, but also the whole process of the successful development, implementation and spread of that idea into widespread use* (ibid.).

The Audit Commission (*Seeing the Light*, op. cit., p.18) also distinguished between:

* Service design or delivery innovation.
* Process or managerial innovation.
* Democratic innovation.
* Strategic innovation.

Examples of all of these can be found in the evolution of public health in the modern day local government environment.

The role of the VCSE sector in promoting innovation was emphasised in the public health reforms and an indication of how innovation is being defined in the sector can be gained through funding requirements for VCSE sector projects. For example, projects under the innovation strand of the DH Voluntary Sector Investment Programme (DH, 2015) need to demonstrate potential for a national impact and new approaches to ‘improving people’s health and well-being’, or delivering health or care services at local or national level (p.22). Such projects should not have been previously evaluated, that is, there is a requirement for doing something new rather than diffusing innovative practice.

Overall, there is much common ground between definitions and we believe that these pointers remain helpful and reflect the varying contexts and responses that we have found in our own case study areas for this current study. We have taken these into account in presenting findings from our case study authorities on innovation across a public health commissioning framework.

Innovation may be evolutionary or revolutionary (sometimes referred to as disruptive innovation) – but implicit in the concept of innovation, whether evolutionary or revolutionary, is the notion and expectation of moving ‘beyond competence’ (Swann et al., 2005). It is not simply a more polished presentation or delivery of what went before. It is also about ‘raising the floor’ and about strategic and practical change, not tactical change.

## 2.2 The changing context

Local government as a whole has an impressive record of responding to the need for change and can generally tell a credible story of self-improvement and innovation. Nevertheless, by its very nature, innovation cannot be something of a one-off, never to be repeated, and there are ever more pressing reasons for its necessity in today’s public services. A number of important contextual changes are relevant, even in the relatively short period since the transfer of public health services (back) to local government was announced. Of particular note are:

* The ongoing financial challenges affecting all levels of government and ranging across authorities and sectors.
* The unsettled complexity of public service accountabilities and provision.
* The ongoing recalibration of the relationship between the different tiers of government, and between the state and the public.

These issues will be referred to in more detail in the responses from our case study sites later in this report but, as Nesta (2013) succinctly puts it, ‘Local government needs to do more and better with less’ (p.12).

## 

## 2.3 Innovation in practice: the implementation challenge

Nesta (2013) indicates that ‘innovation is fundamentally a team activity’ (p.10) and that ‘the real innovation challenge is not about having the idea, but working out how to turn those ideas into action’.

It has also helpfully set out what it calls the ‘seven stages for innovation’:

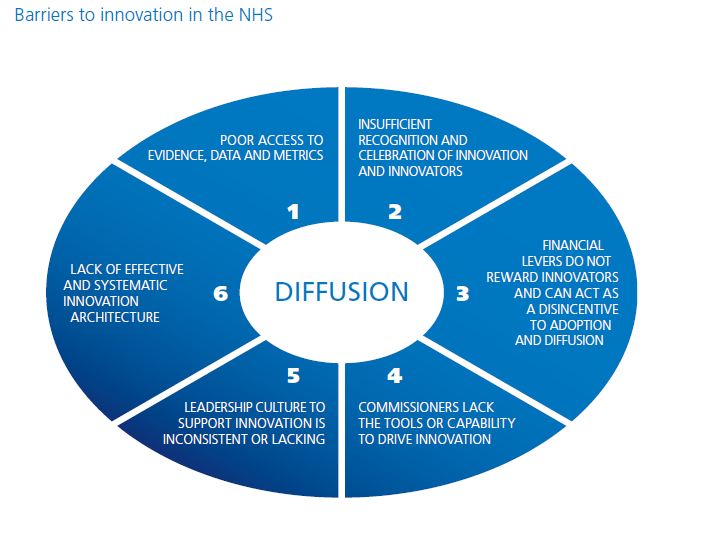
1. Opportunities and challenges.
2. Generating ideas.
3. Developing and testing.
4. Making the case.
5. Delivering and implementing.
6. Growing and scaling.
7. Changing systems.

([www.nesta.org.uk/resources/understand-how-innovation-works](http://www.nesta.org.uk/resources/understand-how-innovation-works), accessed 04/09/16)

But barriers to innovation abound. *Seeing the Light* (op. cit., pp. 37-39) cited nine potential barriers to implementing innovation in local public services:

* Failures in risk assessment and risk management;
* Over-estimation of capacity;
* Lack of effective leadership or strategic input;
* Poor organisation and communication among senior officers;
* Absence of or poor quality project management;
* Inadequate reporting to [elected] members;
* Failings in the use of external advice;
* Poor management of contractual partnerships;
* Poor procurement practice.

Focusing specifically on the NHS, but with clear applicability more widely, *Innovation Health and Wealth* (op, cit., p.10) illustrated similar barriers in graphic form:



Leadership and ‘buy-in’ are often seen as key to overcoming barriers. Fundamentally, innovation cannot take place in isolation from those whose behaviour it is intended to influence and change. As the ‘Accelerating Innovation in Local Government Research Project’ (Local Government Association (LGA), 2013, p.1) put it: ‘Build a united political and managerial leadership approach to innovation’ and ‘convincingly communicate the need for innovation to residents, employees and partners’.

## 2.4 How best to spread and embed innovation?

There is an ever greater desire for increased levels of innovation. But the need to embed innovation is important too if it is going to survive and prosper once those seen as responsible for the innovation have departed or have moved on to other matters. Leadership and buy-in is crucial but it is important also to recognise the importance of human relationships and individual partners and practitioners believing in the innovations, or at the very least not actively opposing them, and changing their own behaviour. Innovation is just the start of a journey given the need for embedding, spread and diffusion if it is to take root. *Innovation Health and Wealth* (op cit., p.11) says that for that diffusion to occur you need as ‘a prerequisite’ a

*supply of ideas, services or products that demonstrably add value in terms of quality and productivity to pre-existing arrangements*

as well as

*a demand for those ideas, services or products from organisations and individuals throughout the NHS.*

This point can be made about public services more widely and arguably the key is with the latter issue (demand – or desire) not the former (the supply of ideas). Following on from the supply of, and demand for, ideas there is then a need for a combination of ‘top down pressures, horizontal pressures [and] bottom up pressures’ (*Innovation Health and Wealth, op cit.*) – illustrated in the diagram below. As the Audit Commission pointed out (*Seeing the Light*, op. cit., p.45), ‘Many local public bodies face the same challenges and can support each other in identifying opportunities, sharing ideas and highlighting potential risks’.



(Source: *Innovation Health and Wealth*, 2011, p.11)

*Innovation Health and Wealth* (ibid.) also tells us that –

*Previous attempts to achieve consistent and widespread adoption and diffusion have tended to fail because all three forces have not been mobilised together*.

Drawing on previous work that we have undertaken on innovation in the public sector (Swann et al, op. cit.) we would suggest that the key *H*organisational factors that are needed for innovation to become part of the organisational way of life – part of the ‘hard wiring’ - include:

* Making strategic choices, deploying tactical flexibility and sticking with it.
* Organisational ambition supported by professional excellence.
* Building capacity and exploiting it – spotting opportunities and exploiting them.

Necessary steps to achieve this include:

* The development of an action research, learning culture in which staff and organisations can push at the boundaries of innovation and implementation – something which can be threatened by the tension between taking time out to do things differently and ‘keeping the show on the road’.
* A new approach to external challenge – to help reframe the present, and rethink and rebalance what is being done now and into the future – and also recognising the then Home Secretary’s criticisms of peer challenge (Rt. Hon. Theresa May, MP, *Home Secretary speech on fire reform*, 24 May 2016).
* Acceptance that some ideas will fail to make it all the way through from ‘lightbulb moment’ to implementation – some degree of ‘failure’ is part of the process of innovation.

Realistically, particularly in the current financially challenged environment, innovations generally need to reduce costs or be cost neutral.

## 2.5 Attitude to risk

It is important to recognise that innovation requires an acceptance of risk – an acceptance that some innovations will not work out as hoped and that some may fail. *Seeing the Light* (op. cit., p.14) notes that:

*Whether authorities invent something new, or adapt others’ ideas to their particular circumstances, innovation requires authorities to embark on something that they have not done before. As such, risk is inherent in the innovation process … Innovation, like any other improvement route, can fail to deliver its intended benefits.*

Learning from failure – and the safe space in which to learn from failures – is therefore an important part of any innovation strategy and journey. Doing things differently can get you into trouble and the safe place to be is in the ‘middle of the crowd’, not standing out and not attracting attention. Sustaining an acceptable appetite for risk is a significant and continuing challenge in driving innovation forward. Innovation inevitably involves moving out of the comfort zone – looking at things differently and from different viewpoints – and may also involve some financial risk.

Alongside this is the notion that innovation may not always be a good thing. The *NHS Five Year Forward View* (2014, p.32), for instance, refers to the need to ‘accelerate useful healthcare innovation’ – with the clear implication that not all innovation is useful. Sometimes it may be that a period of stability is what is required rather than further change. There can be a danger that the new and unproven may enjoy rapid diffusion and as Dixon-Woods et al. (2011) point out, ‘terms such as “breakthrough”, “radical”, “new” and even “innovative’’ ‘ raise expectations and emphasise ‘the appeal of the new and the rejection of the dull’. Furthermore, some innovation can have a possibly detrimental effect or other unintended consequences. There are some indications of this in the views of interviewees and survey respondents around issues such as the potential ‘squeezing out’ of small providers, and whether public health professionalism is being ‘downgraded’ as a result of the organisational changes consequent upon the reforms.

## 2.6 Innovation and public health

Almost the only area of agreement, therefore, over innovation is that a single definition is elusive. It may be used to signify a development which is perceived as improving outcomes (and also reducing cost) but which has not been widely ‘diffused’, a development which is original in itself or which is new in a particular context or for particular stakeholders, or a change which is in some way identified with ‘transformation’ or ‘improvement’.

Public health innovation raises additional, discipline specific issues. It can be argued that factors improving health are already well understood, have been promoted through national and international initiatives for many years, as well as through both health and local authorities, and that improvement in population health is less about innovation in particular services than about a commitment to put health first and to address social determinants of health and health inequity in a systematic way (see, for instance, Marmot, 2015). The Audit Commission, amongst others, has also previously argued that, ‘There needs to be more ruthless targeting of money and services with close attention paid to outcomes’ (Audit Commission, 2010, p.13).

Given the long-standing activity by many local authorities in seeking to address health inequalities and in health impact assessment, including involvement in the Healthy Cities Network (<http://healthycities.org.uk/>, accessed 04/09/16), innovation may rest less in understanding the relevance of public health being located within local authorities than on whether this has led to changes in practice.

Nevertheless, what constitutes innovation in public health policy and practice is attracting increased interest (see, for example, Hancock, Barr and Potvin, 2015). In a study which attempted to define innovation in public health, Fung, Simpson and Packer (2010) note that ‘innovation in public health has not been defined’ and, based on a quasi-Delphi study (largely of public health professionals) concluded that:

*Innovative public health interventions (PHIs) are generally new and different to established interventions. They should be equitable, applicable to all in a population, cost-effective and may address health determinants in the non-health sector of society. A good evidence base is ideal but sometimes it may be necessary to consider PHIs lacking evidence*.

This emphasis on equity, social determinants and on population-wide interventions reflects discipline-specific elements of public health innovation which need to be reflected in frameworks for public health commissioning. In this report, we consider how innovation related to public health was defined and illustrated across a range of different groups and sectors, including, but not limited to public health professionals.

## 2.7 Levers for diffusion of innovation

As well as attempting to define innovation, writers have considered diffusion of innovation in local government: how and why innovative ideas are implemented, become embedded and are shared. Bartlett and Dibben (2002) note the importance of leadership, referring to ‘champions for innovation’ and dividing these between the ‘public champion’ and the ‘empowered champion’. Public champions are those who champion their proposals for innovation through the established local authority decision-making procedures. Empowered champions are motivated by more personal concerns and an enjoyment of the change process itself (p. 112). Bartlett and Dibben conclude that whilst these champions lead, they may not necessarily hold a senior managerial or political leadership position. However, both will require a sponsor who can provide a mandate or political support if their innovative ideas are to be implemented and attain any level of sustainability. In an empirical analysis of the diffusion of innovation across English local government, Walker (2006) identified a range of factors including the external context, organisational characteristics and ‘diffusion drivers’. The analysis concluded that ‘it is likely that demanding and complex environments will increase the likelihood of a public agency seeking new solutions to meet the needs of its citizens and users’; very much the environment in which local government exists currently. In addition, like Bartlett and Dibben, the analysis identified the importance of leaders as drivers of innovation and its diffusion. He concludes that ‘in public organizations such as local authorities, which are democratically elected, the role of politicians is likely to be extremely influential in the adoption of innovations’, providing the sponsorship described by Bartlett and Dibben. Senior managers are likely to influence culture and motivate staff to innovate, and there is some evidence that managers new to the organisation, bringing with them experience of practices from elsewhere, may bring new innovative ideas and practices (p. 315).

Within health services, as indicated above, it has been suggested that diffusion and embedding of innovation is also dependent on a combination of factors. *Innovation Health and Wealth* (op. cit.) suggests that there is a need for a combination of ‘top down pressures, horizontal pressures (and) bottom up pressures’ to drive and sustain innovation. These factors of innovation can be considered alongside those described in local government (Table 1):

Table 1: Levers for innovation

|  |  |  |  |
| --- | --- | --- | --- |
|  | ***Innovation Health and Wealth*, 2011** | **Walker, 2006** | **Bartlett and Dibben, 2002** |
| *Downward* | *Top down pressures*: Central requirements, regulation and incentives; and support, such as guidance and skills development | Democratically elected political leaders | Innovation sponsor |
| *Sideward* | *Horizontal pressures*:  Peer influence, transparent reporting, collaboration, competition and effective marketing from external suppliers | Organisational size, influence of established and new managers | Public and/or empowered champions |
| *Upward* | *Bottom up pressures*:  patient and public demand for best practice, professional and managerial enthusiasm, entrepreneurialism and choice | Complex and demanding environments demanding new solutions | Empowered champions |

Drawing on the models developed in *Innovation Health and Wealth*, Walker and Bartlett and Dibben, this report considers these downward, sideward and upward characterisations of innovation pressures together. In this report, they are described thematically as ‘levers for innovation’, as they relate to population health and preventive services.

* ‘Downward levers for innovation’: innovation which occurs as a result of local authority directorates, including public health teams, being encouraged or mandated to pursue targets or strategies set by the local authority or central government departments or agencies. These levers are applied through democratically elected political leaders at central government and local government levels, either directly or through sponsorship. It should be noted that, following public health reforms, there could be friction between these levers, requiring a DPH to balance the encouragement or mandates of central government with those of local government.
* ‘Sideward levers for innovation’: innovation which occurs as a result of partnerships, alliances or networks across departments or organisations, where partners do not have power to compel other partners to take action, but where all participants perceive benefit.
* ‘Upward levers for innovation’: innovation which occurs from leverage associated with complex public health problems requiring new solutions, local priorities for reducing inequalities between different groups or areas; professional responsibilities related to the public health function, such as meeting needs of underserved communities or individuals; high levels of morbidity, mortality or poor social outcomes when compared with comparable areas, and local pressure. This may include leverage arising from representation or demand for increased or new services, although historically demands for health services have tended to predominate. It may also involve leverage arising from evidence of action and need amongst communities or individuals and questions around engagement with the current public health offer.

In practice, these levers for innovation are likely to work inter-connectedly. Furthermore, there may be examples of a sole agent applying more than one type of lever. For example a DPH may act as a sideward lever for innovation through working within a partnership with other local authority departments or external organisations, but may also act as an upward lever for innovation by making representations to decision-makers in local and central government.We return to these issues in section 4 of this report.

## 2.8 Public health frameworks and their relevance for innovation

Developing an innovation framework for public health commissioning brings together different approaches to innovation (as reflected through local government and the NHS), with frameworks used to describe public health activities and functions. The latter have been conceptualised in different ways. For WHO European Region, the *European Action Plan for Strengthening Public Health Capacities and Services* (WHO, 2012) identified ten ‘avenues for action’ reflected in ‘essential public health operations’, as follows:

1. Surveillance of population health and wellbeing.

2. Monitoring and response to health hazards and emergencies.

3. Health protection including environmental, occupational, food safety and others.

4. Health promotion, including action to address social determinants and health inequity.

5. Disease prevention, including early detection of illness.

6. Assuring governance for health and wellbeing.

7. Assuring a competent public health workforce.

8. Assuring organisational structures and financing.

9. Advocacy, communication and social mobilisation for health.

10. Advancing public health research to inform policy and practice.

Whilst these ‘avenues for action’ reflect well-established categories for the public health function (and innovative practice can be reflected through each of them) it is also the case that a systematic approach to implementation across the range of essential public health services and/or the implementation at scale of relevant interventions is required for improving health and addressing health inequalities.

*The Public Health Outcomes Framework for England* (DH, 2012) provides two high level, overarching indicators and further detailed indicators across four separate domains, namely: improving the wider determinants of health; health improvement; health protection; healthcare public health and preventing premature mortality. As well as providing a framework, this also offers local authorities a means for comparing local progress against that of comparable authorities and areas. Success in achieving improved outcomes may, in some cases, result from innovative approaches to commissioning.

Finally, the Marmot Review of health inequalities in England (2010) provided six policy principles for reducing inequity:

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 a healthy standard of living for all.

5. Create and develop healthy and sustainable places and communities.

6. Strengthen the role and impact of ill-health prevention.

Relevant indicators have been produced for local authorities and the Marmot approach has been widely embraced by local government. However, it should be noted that the six policy principles do not cover the full range of public health functions.

In this report, we consider the extent to which the transfer of public health responsibilities (back) to local government has promoted innovation in traditional preventive services (such as lifestyle services, sexual health services, and drug and alcohol services) and, equally, the extent to which a public health dimension has been encouraged in commissioning other local authority services. Whilst ‘commissioning’ is often associated with contractual elements associated with the purchasing phase of a commissioning cycle, commissioning for health and wellbeing involves working across the spectrum of local public services to address wider determinants of health. Procurement of specific preventive services will form only part of this wider agenda. Definitions of what is involved in commissioning public health services are changing as local authorities broaden the debate over the parameters of preventive services.

Sub-section 4.3 draws on views of both interviewees and survey respondents in order to develop a public health commissioning framework with a focus on innovation, and illustrated by examples of innovation raised during the research process. However, this is not a comprehensive public health commissioning framework and does not, therefore, include all the elements listed in the above frameworks, despite their relevance for public health commissioning.

In order to provide a context, Box 1 (below) provides a summary of how ‘transformation’ since the reforms has been perceived, as reflected through four LGA public health transformation reports to date (LGA and PHE 2014, LGA 2014, 2015c, 2016b). Whilst these reports focus on individual case studies (and some of the initiatives listed preceded the implementation of the reforms), our data reflect similar themes.

Box 1: Transformation in public health: the LGA transformation reports

*Innovations in public health commissioning*

* Using local authority tendering expertise.
* Listening to local communities/community-provided services.
* Greater involvement of communities in the Joint Strategic Needs Assessment and also new approaches to its dissemination.
* Holistic approaches to health and wellbeing and lifecourse approaches - linked to local authority services.
* Social models (e.g., for sexual health services).
* Developing community asset-based approaches.
* Developing volunteers (and incentives such as time credits).
* Commissioning for social value.
* New venues (libraries) and providing health promotion services in children’s centres.
* Leisure initiatives.
* Workforce initiatives (e.g., the involvement of fire and rescue services – see also LGA 2015a, 2016a).
* More emphasis on social isolation and mental health services.
* Working with a range of providers, including social enterprises and also working with volunteers.

*Support for local authority service development*

* Data analysis and health needs assessment across the board.
* Integration of health across strategies (e.g., domestic violence, and drugs and alcohol).
* More involvement with vulnerable groups and social care, including looked after children and vulnerable adults, refugees and migrants, dementia support, services relating to domestic abuse, housing support services, supporting discharge.
* Involvement in demand management initiatives.
* District Council involvement in public health in non-unitary areas.

*Engaging with wider determinants:*

* Working across directorates and services, including planning, regulation and trading standards (e.g., concerning takeaway outlets), transport (e.g., cycle lanes, speed zones, and other road safety issues); influencing the ‘social architecture’ (e.g., betting shops, screening licensing applications, mapping alcohol outlets, mapping food outlets, night time economy management), air quality; winter warmth initiatives.
* Systematic involvement of other directorates and services in delivering aspects of the Public Health Outcomes Framework backed by delivery agreements and incentivised through the public health grant.
* Health and wellbeing included in all job descriptions across the council.
* Working with social housing, leisure services.
* Systematic approaches.

*Decision making processes*

* Health impact assessment for all major developments.
* Support of elected members in task and finish groups, links to communities, making links across portfolios.

Other innovations include the sharing of public health posts and services between a number of local authorities, the creation of a HWB in Alcester, Warwickshire, at Town Council (i.e., parish) level and fitting in with Warwickshire County Council’s resilience initiative (Alcester Town Council, 2014; see also [www.ouralcester.org.uk/health-wellbeing-board/](http://www.ouralcester.org.uk/health-wellbeing-board/), accessed 07/06/2016), and the health devolution coming about through Combined Authority agreements (e.g., HM Treasury and Greater Manchester Combined Authority, 2014).

It is important to acknowledge that, by the very nature of statutory reorganisations, we do not have a counter-factual – though the absence of a counterfactual affects our ability to measure impact, not the impact itself. We do not think that this undermines the value of the innovation that has taken, and is taking, place.

The move of public health (back) to local government is in itself an important innovation bringing with it greater exposure to local democratic pressures and forces, as well as new dialogues. Wider and ongoing changes in the nature of the public sector and local public services mean that cross-disciplinary working has become the norm in local government. There are also willing partners in other services (e.g., fire and rescue) that may not have existed to the same extent in the past. Innovation may therefore rest on the extent to which action is reflected across the breadth of possible activity (see, for instance, LGA 2015b, LGA and ADPH, 2016). It is also important to always bear in mind that:

*The nature of public health is that the improvement in …outcomes will take years – sometimes even decades – to see marked change* (Department of Health, *The Public Health Outcomes Framework for England 2013-2016*, 2012, p.3).

Timescales from initiation to outcomes are an ongoing challenge.

# 3. Methods

This report brings together findings related to innovation from different elements of the study. A specific question on innovation was included as part of the following project activities: (i) initial interviews with national stakeholders; (ii) national surveys (2) of DsPH and CCG members of HWBs; (iii) a national survey of local Healthwatch and VCSE sector members of HWBs; (iv) a national survey of VCSE sector organisations involved in health promotion and prevention; (v) interviews (90) carried out with stakeholders in ten case study sites across England. Innovation-related questions were tailored to the groups being interviewed/surveyed. However, views on innovation also emerged throughout the research process. For example, interviewees were asked their views on advantages and disadvantages of the reforms, changes in how preventive services were being commissioned and specific questions on the impact of the public health reforms on how and where services were provided and on community engagement, which also led to discussion of innovative approaches. Analysis was not, therefore, limited to responses directly related to innovation questions as outlined below.

New analyses (using framework analysis (Ritchie and Spencer, 1994, pp. 173-194), supported by NVivo 10) of interview data were carried out in relation to definitions of innovation (sub-section 4.1) and to levers for innovation (sub-section 4.2). In addition, documentary analysis was used to supplement suggestions raised by interviewees in order to provide examples in sub-section 4.3.

Box 2 summarises innovation questions included as part of project activities. Research Reports 1, 3, 4 and 5 include further details of methods adopted for each element of the study as well as summaries of findings on innovation (reports 1, 3 and 4 are available at <https://www.dur.ac.uk/public.health/projects/current/cphs/>).

Box 2: Questions on innovation

|  |
| --- |
| **(i) Interviews with national stakeholders**  All interviewees (n=11) were asked the following question: *Do you consider that new public health responsibilities are encouraging innovation in public health services? If so, which kinds of innovation?* |
| **(ii) National surveys of DsPH and CCG members of CCGs:**  two surveys carried out a year apart. The first survey had 39 respondents and the second had 35 respondents.  Respondents were asked the following questions: (1) *The public health reforms placed an emphasis on encouraging innovation in providing preventive services at a local level. In a few sentences or by providing a few key words, how would you define innovation in this context?* (2) *Has your local authority created a climate for developing innovative approaches to public health by doing any of the following: prioritising areas where innovation is needed; providing opportunities and time allocation for developing innovation; facilitating cross council working with key partners; testing new approaches to public health services; formally acknowledging efforts to develop innovative working; learning from failures; providing financial incentives for achieving improved health resulting from innovative ideas /services; using the ring-fenced public health budget to encourage innovation; commissioning for integrated services. (Qs 18 and 19)* |
| **(iii) National survey of Healthwatch and VCSE sector members of HWBs**  Respondents (n=34) were asked the following questions: (1) *The public health reforms placed an emphasis on encouraging innovation in the provision of preventive services at a local level. In a few sentences or by providing a few key words, how would you define innovation?* (2) *Have the public health reforms enabled innovative approaches to public health services in your local authority area for the following services to underserved groups and areas: developing community networks; addressing social context and conditions; addressing unhealthy lifestyles; involving community champions; co-design of services (younger people); co-design of services (older people); co-design of services (other groups) (please specify); using incentives; accessing services.* (3) *If you would like to highlight examples of local innovation, please do so in the box provided. If possible please provide links to documents/websites or provide contact details of individuals/organisations who may be able to provide additional information.* (*Qs 19-21)* |
| **(iv) National survey of VCSE sector organisations involved in health promotion and the prevention of ill health**  Respondents (n=39) were asked the following questions**:** *The reforms placed an emphasis on encouraging innovation in the provision of health and wellbeing services at a local level. In a few sentences or by providing a few key words, how would you define innovation? If you would like to highlight examples of local innovation, please do so in the box provided. If possible please provide links to documents/websites or provide contact details of individuals/organisations who may be able to provide additional information. (Qs27 and 28)* |
| **(v) Fieldwork in 10 case study sites across England**  Interviewees (n=90) included the DPH, CE, Service and Executive Directors (Adult Social Care/Children’s Services/People/Communities), a CCG member of the HWB (usually Vice or Co-Chair), HWB Chair, Health Scrutiny Committee Chair, NHSE member of the HWB, Healthwatch Chair and a representative from the VCSE sector. They were asked the following questions (unless relevant information had been obtained in response to other questions): (1) *How would you define innovation in public health?* (2) *Could you provide any examples of innovative approaches to improving health and addressing health inequalities in your local authority?* (3) *Are there ways in which the local authority supports innovation in public health?* (4) *Are there incentives in place to encourage improved public health outcomes?* |

Whilst Research Reports 1, 3, 4 and 5 summarise key findings related to innovation, in this report we consider data across all elements of the study in order to identify similarities and differences across sites and by role, and reflect a range of examples across public health commissioning.

# 4. Results

Results are presented for the following areas: definitions of innovation (4.1); levers for promoting and diffusing innovation (4.2); examples illustrating an innovation framework for public health commissioning (4.3); and the extent to which innovation is being encouraged since the public health reforms (4.4).

## 4.1 Definitions of innovation

**4.1.1 Introduction**

Building on previous separate summaries of innovation included in Research Reports 1, 3, 4 and 5, this sub-section brings together findings related to defining innovation arising from six sets of data which comprise the study to date. It begins by focusing on definitions offered by interviewees from ten case study sites and survey respondents from four national surveys (4.1.2). The sixth set of data concerns interviews with national stakeholders, carried out as part of a scoping phase, where a more general question on innovation was asked: these data are summarised separately (4.1.3). Results from the national surveys (2015 and 2016) of DPH and CCG members of HWBs are compared (4.1.4), followed by a brief comparison by site, illustrating differences in emphasis (4.1.5). Views over what constituted innovation also emerged through responses to other questions in interviews carried out in case study sites and these are reflected in examples included in sub-section 4.3.2.

As outlined in the methods section of this report (section 3), respondents were asked to define innovation in the context of preventive services and public health. Table 2 summarises five of the six sets of data. Survey questions related to definitions of innovation were deliberately left open in order to reflect a range of views and a thematic analysis of responses was carried out. There was great variation in the length of responses by interviewees in case study sites and data are therefore not quantified in Tables 3-11, below but are included in the analysis for each dimension of innovation whilst the spread of views by case study site is summarised in sub-section 4.1.5. Out of 90 interviewees, 69 were asked a direct question on innovation, but not all provided a definition. Combining the five data sets generated 188 individual pieces of data relating to definitions of innovation (Table 2).

Table 2: Sources of data on definitions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Invited | Responded | Anti- question | Anti- concept | Gave a definition |
| Interviewees in ten case study sites who were asked to define innovation | 68 | 67 | 6 | 6 | 61 |
| National survey of DPH and CCG members of HWBs (first survey) | 39 | 37 | 1 | 1 | 31 |
| National survey of DPH and CCG members of HWBs (second survey) | 35 | 35 | 0 | 1 | 32 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 39 | 38 | 2 | 4 | 33 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 34 | 34 | 2 | 1 | 31 |
| **Totals** | **215** | **211** | **11** | **13** | **188** |

Some interviewees and survey respondents refused to give a definition of innovation and/or rejected the concept of innovation in public health. Some refused to define innovation because they believed it was an ‘overused word’, or just ‘common sense’ (VCSE sector survey), but others challenged the purpose of the research question. A HWB Chair noted:

*I think it feels to me like trying to find good news really, and it would be misleading for the Department [of Health] to come away and think ‘oh actually yeah, we’re getting more from less’*.

Interviewees and survey respondents sometimes refused to give a definition because they rejected the concept of innovation in public health. A CCG interviewee expressed a view that was also shared by some other CCG and DPH contributors:

*I’m not sure that we do anything innovative; we just simply apply what works. And if that’s innovative then yeah we’re innovative. But actually we’re not inventing anything new, we’re stealing other people’s ideas. There’s not much of what we’ve talked about which is innovative as in ‘new’.*

Others, such as a VCSE sector survey respondent felt that it was unhelpful to think about innovation, when much of their work was dependent on providing evidence of outcome, concluding that ‘innovation shouldn't come at the expense of initiatives which have already been shown to work’. An emphasis on the new as opposed to the effective could be counterproductive and a VCSE sector respondent (Healthwatch/VCSE sector survey) noted that:

*Innovation is not always what it is about. I believe through too much innovation we have lost some integrity and fidelity to provision*.

A further concern was that innovation was used to mask funding cuts, a smokescreen when funding was being reduced. A respondent (Healthwatch/VCSE sector survey) noted that:

*What is really meant by innovation? Don’t we just mean doing more despite massive funding cuts? … But I think it is a bit of a joke expecting people to be innovative because innovation means space to be creative and you can’t take risks with creative ideas in a climate where there is so little funding.*

Limitations of local innovation in the absence of national action were also emphasised (DPH/CCG survey (1)) as was the importance of developing locality-based approaches. Despite these caveats, most interviewees and survey respondents did contribute a definition of innovation.

**4.1.2 Innovation dimensions**

When responding to the request to define innovation, interviewees and survey respondents varied in their approach. Some described innovation as an action, whilst others described innovation as an outcome, detailing the conditions necessary for innovation to occur or detailing sources of innovation. Some saw it as a ‘cast of mind’, rather than a particular procedure or related to a specific discipline, that is, being open-minded, flexible and not risk averse. Others emphasised innovation as a process, that is, ‘new, different, smarter, leaner, personalised’ (VCSE sector survey). A context of complex and interrelated problems which required innovative solutions, combined with the need to save money, also framed many responses. A respondent (DPH/CCG survey (1)) noted that it was important for public health innovation to be seen in the context of:

*understanding system complexity and transformation programmes for children’s and adults’ service areas and ensuring public health provides additionality.*

Some respondents differentiated between various categories of innovation. For example, one respondent (VCSE sector survey) differentiated between social innovation (developing new ideas to meet social problems), societal innovation (system-wide change across a whole society) and innovation resulting in a stronger capacity for action. The same respondent also referred to different models of innovation (incremental, adaptive, radical and disruptive). Another highlighted the differences between ’blue sky’ and ‘early adopter’ innovation. Sources of innovation included new providers (leading to new models of provision), user involvement, and learning from good practice elsewhere, adapting findings for local contexts. One respondent (DPH/CCG survey (1)) saw the movement towards a population-based approach, as reflected in the Marmot Review, as innovative, perhaps implying that implementation was lagging behind, despite adoption of the six Marmot policy principles by many local authorities.

Thematic analysis of the different sets of data identified nine main dimensions of innovation:

1. Innovation being or resulting in something new.
2. Innovation achieving a better outcome.
3. Innovation resulting from increased engagement and co-production.
4. Innovation resulting from risk taking.
5. Innovation resulting from collaborative action.
6. Innovation arising from understanding need.
7. Innovation arising from evidence of what works.
8. Innovation resulting from charismatic leadership.
9. Innovation driven by financial concerns and achieving more with less.

Respondents sometimes included a combination of these dimensions in their definition of innovation, such as new or creative solutions which provided better outcomes at less cost. As one VCSE sector respondent noted, innovation was ‘the happy marriage of creativity and effectiveness’.

Tables 3-11 include results from the four national surveys only: numbers refer to references not respondents.

Table 3: ‘Something new’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 8 |
| National survey of DPH and CCG members of HWBs (second survey) | 4 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 17 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 22 |
| **Total references** | **51** |

Newness was, unsurprisingly, commonly associated with innovation, even if this was not explicitly stated. Some interviewees and survey respondents believed that innovation was ‘trying to do things in a completely new way’ (DPH), or ‘new ideas and new ways of doing things and thinking about things by offering a holistic approach’ (VCSE sector survey). Innovation was described as being applied to a service or to other methods for improving public health. In particular, both VCSE sector and Healthwatch/VCSE sector surveys identified the importance of new and fresh approaches. However, for some, being new and untried was less important than achieving a better outcome, and some felt that newness was only one dimension of innovation.

Table 4: ‘Achieving a better outcome’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 4 |
| National survey of DPH and CCG members of HWBs (second survey) | 4 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 7 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 14 |
| **Total references** | **29** |

Achieving a better outcome was often included in definitions of innovation. Doing ‘what works’ was sometimes associated with achieving better outcomes at less cost – that is, both more effective and more efficient. A DPH emphasised the need for innovation to be outcome-focused as well as new:

*Innovation is something that hasn't been done before. But it has been implemented. So it's not an innovation until it's happening. And I would say a public health intervention is something new that has been implemented that is being evaluated and it has a degree of evidence base and political sign-up behind it.*

This view was shared by a VCSE sector survey respondent who believed that:

*Innovation is looking at the fundamentals you are trying to achieve and working out the best way to achieve them. This may not be the same way as you do now. It may be a small improvement on what you do now, or a complete change of approach. It uses new methods, including new technologies, and new providers, not for the sake of newness but because they offer a better way of doing what needs doing.*

This might involve being ‘less process-orientated and more outcomes-driven’ or ‘more targeted’ and involve a continuing assessment of ‘what works well’ and then building on this, although some respondents saw little evidence of this locally (Healthwatch/VCSE sector survey). In some cases, an improved outcome was the only definition of innovation. For example, a respondent (DPH/CCG survey (1)) summed up innovation as:

*Using a simple approach to make an improvement.*

Almost a quarter of respondents to the VCSE sector survey and almost one half of respondents for the Healthwatch/VCSE survey emphasised the importance of providing cost-effective services, achieving greater impact for individuals and the community for less cost.

Table 5: ‘Increased engagement and co-production’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 7 |
| National survey of DPH and CCG members of HWBs (second survey) | 7 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 8 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 5 |
| **Total references** | **27** |

Achieving increased engagement and co-production with communities of interest or of place, developing ‘shared solutions to common problems’ and also promoting local resilience, were frequently mentioned dimensions of innovation and contrasted with top-down modelling of preventive services. Sometimes this was in relation to the planning of services, as ‘something new to get people involved’ (VCSE sector survey), or:

*working together to deliver something that works and is sustainable and that includes local people and communities at the heart of it.* (Healthwatch/VCSE sector survey)

One CE emphasised the importance of community engagement in developing innovative solutions:

*It’s a general understanding over time here that … if you’re going to find creative solutions to some of the issues we’ve got, the answers aren’t in the town hall are they? …. We need to work with people in order to get them.*

Where innovation might be defined as ‘doing things differently’, one respondent emphasised that a process of trial and error needed to involve users throughout the process, identifying what worked (Healthwatch and VCSE sector survey). A further respondent noted that as:

*health and social care works in a constantly evolving innovative environment. Innovation for me is where we really listen to the local residents to see how they view their needs and priorities then translate that into service delivery to achieve that outcome together. There is still a culture of standardised services fitting around people not a more personalised approach which may be more costly initially but will be the only way to create the behaviour change required in the longer term.*

For others, innovation would also lead to communities taking responsibility for their own health. One service director believed that innovation was about newness and about improved outcomes, but it was also about achieving shared responsibility:

*Meeting outcomes, I think the innovation I think has to be in really thinking differently in how we support our population and our residents and whether they’re adults or children. How do we offer services that work in a different way and how do we build the capability in communities to do some of that themselves.*

A service director from a different site felt that innovation would be achieving:

*a massive cultural change in [place], whereby people felt that they wanted to take control of their health and wellbeing as opposed to having an expectation that it was something that public services would do for them.*

Underlying these data was an acknowledgement that individuals and communities were best placed to understand their needs and offer innovative solutions. A VCSE sector survey respondent spoke of innovation arising from ‘asking those that use services how they find it and what they would do differently’, of being ‘responsive to people’s experiences and deficits in services, and quick to work with people on their own terms’. In one site, the DPH spoke of the importance of viewing people as an ‘asset in their community’, and not as a ‘problem’. Other statutory sector interviewees and survey respondents gave examples of community asset-based approaches, with individuals being viewed and supported as assets to their communities and to service providers, rather than being viewed only as consumers or beneficiaries of services. One respondent (Healthwatch and VCSE sector survey) noted the importance of a blend of asset and deficit-based models. Seven of the DPH/CCG survey respondents (survey 1) identified the importance of ground-up, ‘customer-focused’ and asset-based approaches, focusing on community resilience and co-production and, in the words of one respondent, ‘changing the power dynamic’. In two cases, this was also combined with achieving better value for money**,** as one respondent noted:

*Working with local communities to better understand their assets and what will work for them, to get the best value for money.*

The second DPH/CCG survey showed a similar result, with an emphasis on new ways of engaging local populations. Issues raised in this context included: ‘health buddies’ to raise awareness of prevention initiatives in the community; ‘community commissioning’; the promotion of social movements; neighbourhood approaches involving GP practices; and enabling local communities to take responsibility for health and wellbeing in their communities.

Furthermore, engagement and co-production were viewed as a dimension of innovation necessary to secure sustainability. A VCSE sector interviewee in a case study site summed this up as follows:

*If you don’t engage community and getting people to develop and change life styles for themselves and have a sense of local ownership, you can put projects in all over the place. But once you’ve gone, if you haven’t actually invested the time on the local people, once you’ve gone you’ve gone haven’t you?*

Engagement and co-production were viewed as vital dimensions of innovation because solutions externally developed and then imposed on communities would not be owned and sustained by communities over the longer-term and were unlikely to prove effective.

Table 6: ‘Risk taking’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 1 |
| National survey of DPH and CCG members of HWBs (second survey) | 1 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 12 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 4 |
| **Total references** | **18** |

A further dimension to innovation was a willingness to take risks, to try things which were not only untried or lacked an evidence base, but where there was no guarantee of success. This was described by one VCSE sector survey respondent as:

*not following trends or perceived wisdom; listening to the end user and then designing the response rather than one-size fits all approach*.

A respondent to the second survey of DsPH and CCGs commented on local political encouragement for ‘innovation and sensible risk taking’ in order to promote ‘community resilience and self-reliance’. A CCG interviewee in a case study site shared the view that innovation required a willingness to take risks, believing innovation required:

*a mind-set that you are prepared to take risks, prepared to fail, prepared to learn from what you do. So when you innovate you’re, it’s going with your hunch. You’re saying what we’re doing at the moment isn’t right. We’ve got to do something different.*

The view was also shared by a case study interviewee from NHSE, CEs (3) and a DPH. The importance of experimentation was emphasised, as opposed to what was described as the tendency of professionals to 'draw funding to themselves'. A CE commented that:

*I'm very much into trial and error and experimentation, learning as you're doing at the local level with the people that we have and the people whose problems we are here to solve. Most people solve most of their own problems. When they don't, they get together with other people with problems like themselves and try and solve them socially, so we can help that as well. And when that doesn't happen, they look to the state to help solve these problems through policies or through instruments or through special programmes.*

Table 7: ‘Collaborative action’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 5 |
| National survey of DPH and CCG members of HWBs (second survey) | 10 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 5 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 4 |
| **Total references** | **24** |

Different kinds of collaboration were raised - with service providers, across directorates, across partner organisations, across counties and boroughs and in relation to specific services. For some, innovation was the result of collaborative action between service providers and, therefore, to be promoted by changing traditional forms of delivery, working with new providers, including the VCSE sector, and providing ‘opportunities/platforms for organisations from all sectors to collaborate to design and deliver local services’ (Healthwatch and VCSE sector survey). This was described simply as ‘new ways of working; involving new organisations, including the voluntary and community sector’ (Healthwatch and VCSE sector survey), or as ‘more work and interaction between health and other groups, e.g., transport, housing, fire and rescue, than there was before’ (DPH/ CCG survey (1)). Local communities were also to be included in such collaborations (Healthwatch and VCSE sector survey).

Also highlighted in DPH/CCG survey (1) was a focus on joined up services across the local authority and the NHS, related to issues such as social isolation, fuel poverty, healthy child programmes and children’s centres, while in the second DPH/CCG survey there was increased emphasis on innovation through redesign related to the integration agenda, and through place-based budgets, which encouraged linkages across services.

Reflecting similar views from the case study sites, one respondent (DPH/CCG survey (1)) mentioned the importance of using existing resources differently, ‘persuading others to use their resources to support public health goals’.

Some interviewees and survey respondents believed that innovation arising from collaborative action was a result of the public health reforms, which had encouraged close working across public health teams and other local authority departments. Four respondents (DPH/CCG survey (1)) cited working across local authority directorates (seen by one respondent as encouraged by the reforms and by another as necessary due to the cuts). A service director in a case study site believed that ‘innovation is coming through the synergy that we find when we bring our collective thoughts together’. Innovation was the outcome of such collaborative action, but the collaborative action was itself a product of the reforms rather than a course of action chosen by the players involved. In other cases, it was emphasised (by a CCG interviewee, for example) that ‘if you have the right relationships, irrespective of organisations, you can still do really innovative things’.

Collaborative action, in the form of cross-directorate working, was also often closely associated with austerity measures. It was observed that:

*The dire financial circumstances of most LAs means that fewer bespoke PH services are being provided or commissioned and the PH grant is being used to prop up ... services that would otherwise have to be cut. This is leading to an increased emphasis on trying to bend the mainstream spending of LAs to get more health gain for the population. (DPH/CCG survey (1))*

Consequently, although beneficial innovations had resulted from collaborative action, it was less clear whether such action would have taken place without drivers such as the public health reforms or austerity measures.

Table 8: ‘Understanding need’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 2 |
| National survey of DPH and CCG members of HWBs (second survey) | 3 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 9 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 0 |
| **Total** | **14** |

This dimension is linked to dimension 3 (see Table 5, above), given its association with community engagement. Some interviewees and survey respondents suggested that increased engagement, co-production and collaborative action were necessary for innovation in order to support another dimension; that of understanding need. A service director in a case study site believed that as a result of the public health reforms:

*innovation has come from assessing needs that aren't being met and looking at ways in which you can begin to address those needs differently.*

As well as responding to unmet need, interviewees and survey respondents also felt an important dimension of innovation was responding on an individual’s terms. A respondent to the VCSE sector survey reflected that innovation could be defined as a:

*new response to identified need or to fill existing provision gaps with flexible redesign. Not following trends or perceived wisdom; listening to the end user and then designing the response rather than a ‘one-size fits all’ approach.*

Table 9: ‘Evidence of what works’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 3 |
| National survey of DPH and CCG members of HWBs (second survey) | 3 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 4 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 1 |
| **Total** | **11** |

Some interviewees and survey respondents rejected the concept of innovation in public health because success did not arise from ‘inventing anything new’, as a CCG interviewee noted. Others focused on identifying, interpreting and applying evidence. A respondent to the Healthwatch/ VCSE sector survey noted that innovation involved:

*looking at areas where they have had to be creative as they need to do a lot with very little - other countries outside the 'developed' world.*

An interviewee from NHSE believed that ‘innovation can come through evidence-based research’ whilst a CE interviewee believed that innovation arose partly from ‘just kind of trying and seeing things’, but also believed that innovation required ‘a good understanding of the data’. A service director interviewee believed that innovation was the result of acting on:

*evidence that, institutions and insights we’ve got to are likely to deliver a better outcome, enough evidence to go for it.*

Respondents also emphasised that the innovative aspect of putting evidence into practice was recognising and adapting to the local context.

There were tensions between implementing the evidence and promoting innovation, expressed as follows by a CCG interviewee.

*We’ve got to do something different. So define that in public health. I think what we tend to do, what tends to hamper innovation generally, and I don’t know whether this is more or less a public health matter, is our desire in the health system to be evidence-based. But you can’t get the evidence without innovating.*

Table 10: ‘Charismatic leadership’

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 0 |
| National survey of DPH and CCG members of HWBs (second survey) | 1 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 1 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 0 |
| **Total references** | **2** |

Charismatic leadership, the ability to inspire others to do things differently or aspire towards higher goals, was mentioned by a few respondents as an important dimension of innovation. One VCSE sector survey respondent described this somewhat lightheartedly:

*I have been nationally recognised by my inclusion in the Independent on Sunday ‘Happy List’ of top 100 community leaders for my Innovation, so practice it daily to keep this charity afloat.*

A DPH interviewee described this dimension of innovation as:

*having a good story to tell, or having a story and then ... telling it in lots of different places, and particularly as a way of gaining support and commitment from a whole range of individuals and organisations.*

Like many of the dimensions of innovation discussed above, charismatic leadership was viewed as a dimension that would be aligned with other dimensions in order to achieve innovation. A VCSE sector interviewee described innovation as something which:

*comes both from experience and the ability to articulate whatever you’re trying to innovate, and it links really in the sense of having the expertise, the knowledge and the research capacity to develop something that you can really put forward as an innovation ... .*

Innovation was consequently a combination of understanding need, understanding evidence, and an ability to communicate and inspire others to dedicate resources in order to take action.

Table 11: ‘Finance driven’/achieving more with less

|  |  |
| --- | --- |
| National survey of DPH and CCG members of HWBs (first survey) | 5 |
| National survey of DPH and CCG members of HWBs (second survey) | 7 |
| National survey of VCSE sector organisations involved in health promotion and prevention | 2 |
| National survey of local Healthwatch and VCSE sector members of HWBs | 1 |
| **Total references** | **15** |

Some interviewees and survey respondents refused to define innovation because of concerns about discussing innovation during a period when financial resources for public health were being reduced. For example, a VCSE sector survey respondent stated that:

*Sadly, I feel the reforms simply latch on to innovation as a buzz word which rings rather hollow when it is just used as an excuse to cost cut.*

Of those who did respond, finance was sometimes viewed as only one dimension of innovation. For example, innovation was described by a Healthwatch/VCSE sector survey respondent as:

*coming up with new cost-effective ideas that can create the greatest impact on a community or on individuals.*

A CE interviewee described innovation as:

*coming up with ideas that improve efficacy at lower cost to the public in ways that are different than was done before, and they're implementable. So it's not just a good idea. It's an idea to change something*.

For these respondents, cost-effectiveness was important, but also important were newness and impact.

A VCSE sector survey respondent defined innovation as ‘a better understanding and investment in prevention’, suggesting that innovation was the result of securing additional resources, or possibly distributing resources differently, in order to invest in prevention. For others, however, a reduction in financial resources was viewed as the sole dimension, and possibly the sole cause of innovation. Sometimes this was viewed positively, as by a DPH interviewee who believed that ‘austerity has become the mother of some quite interesting innovation’.

However, others felt that this was not positive. Alongside the DPH/CCG survey respondent who believed that innovation through collaborative action was the result of the ‘dire financial circumstances of most LAs’, a respondent to the same survey defined innovation simply as ‘doing more with less money’. Effectiveness and efficiency were also specifically cited by five respondents (DPH/CCG survey (1)), to be achieved through redesign of services or using existing resources differently to achieve desired outcomes. One respondent noted that ‘dwindling resources’ meant that the VCSE sector would be encouraged to ‘step in with a different approach’.

**4.1.3 Interviews with national interviewees**

The data analysed above review ways in which innovation was defined. Interviews with national interviewees, carried out as part of the scoping phase (and reported in Research Report 1), asked a slightly different question but confirmed some of the views mentioned above. Too much central oversight and monitoring could stymie local innovation in what was intended to be a locally-led public health system and public health innovation depended on partnerships and engagement between public health teams and elected members. Innovation was required in order to reduce demands on services, including social care services, and to address health inequalities and it was noted that ‘the fully engaged community, was a prerequisite not only for a sustainable NHS, but also for addressing the social determinants of health and health inequalities’. However, there was more emphasis on the potential for innovation than on examples of innovative practice. This may reflect the fact that interviews were carried out at an earlier, scoping stage of the study.

**4.1.4 Comparing national survey results**

In the first national survey of DPH and CCG members of HWBs, carried out in August 2015, most definitions of innovation could be grouped (singly or in combination) into the following dimensions: asset and place-based approaches; cost-effectiveness; cross-directorate and multidisciplinary working – with newness and community-based approaches most often cited. In the second national survey, carried out in July/August 2016, the most common responses could be grouped into newness, collaboration (including the integration agenda), new ways of engaging with populations, including neighbourhood and asset-based approaches and doing more with less. Other issues raised included the use of new technologies, non-traditional providers and new ways of narrowing the health inequalities gap.

As for surveys of (1) voluntary organisations involved in health promotion and prevention and (2) Healthwatch and VCSE sector members of HWBs, responses were similar across most dimensions, especially in the way that innovative practice was seen as deriving from views of communities and service users, using co-design or ‘agile’ design. However, VCSE sector respondents were more likely to mention risk- taking and local Healthwatch more likely to mention improved outcomes. Both surveys also reflected a view that the term ‘innovation’ was over-used and a potential smokescreen for budget cuts. Examples of innovative approaches included targeting, developing community networks, integrated approaches to wellbeing and prevention, a single referral route for health and social care workers for preventive services provided through the VCSE sector, and the use of smartphones and skype. The survey of voluntary organisations involved in health promotion and prevention included a greater number of open questions and focused on approaches to, and examples of, innovation: 26 projects were highlighted by respondents. Projects included use of volunteers to raise awareness of screening programmes; integrated wellbeing projects; cross-boundary approaches to address social isolation; and mental health issues.

**4.1.5 Comparing case study sites**

Interviewees were asked a broad question – to briefly describe how they understood innovation in public health. Many answers fell into generic rather than public health-specific categories, such as ‘strategic leadership’, ‘trying out new things’, ‘improving outcomes for less money’, ‘improving services’, ‘thinking outside the box’ and ‘using technology’.

Analysis by site demonstrated some differences of emphasis across different dimensions of innovation, summarised below. Further details on levers as well as incentives for innovation are included in sub-section 4.2, whilst projects illustrating innovative approaches are included in sub-section 4.3.

**Site A**: interviewees in site A reflected views over newness, improving access and outcomes but with greater emphasis on the evidence base. The HWB Chair referred to having a ‘fairly regimented way for doing things’, using the area’s Research Observatory and other data to identify areas of inequalities and deprivation, and target resources accordingly. The DPH confirmed this view, noting that:

*where you’ve got evidence-based services, then I think actually we need to implement those rather than keeping trying to dream up new ideas.*

The preference for concentrating on approaches which were known to work, rather than on developing new approaches, was shared by others within the local authority. This approach was not viewed negatively by the VCSE sector interviewee, who viewed the local authority as nonetheless having a positive culture and being ‘open for discussions and for ideas and solutions’. All examples of innovation were based on partnership working, including multi-agency partnerships to address ‘wicked’ issues which incorporated health and wellbeing. However, there was also a level of questioning over the importance of innovation, with one interviewee observing that:

*there are enough things that work and there is enough variation in the implementation of those that we ought to get on and do everything we possibly can do, to start with.*

**Site B:** interviewees shared many of Site A’s views on defining innovation (such as newness, community engagement and sustainability), along with emphasising the importance of delivery. There was a wariness about focusing too heavily on innovation, with one interviewee observing:

*I’m not sure that we do anything innovative; we just simply apply what works.*

However, innovation was emphasised as a hallmark of this local authority’s approach and linked in to wider transformation of the public sector. Many of the examples of innovation involved investments in small-scale community projects, or the transfer of certain council-owned assets to community ownership, all of which were anticipated to result in improved health outcomes for targeted communities. This change in ownership also often led to savings in service costs and even the generation of profits. Interviewees from the local authority and the VCSE sector noted that financial cuts had reduced opportunities for funding innovative projects, but this was not automatically viewed negatively. The more rigorous testing had led to greater attention being paid to outcomes, particularly for targeted groups.

Developing an innovation culture among staff was a key priority in this site and aligned with staff training to recognise the needs of different groups, so that services were not developed in a top-down or bureaucratic way but reflected the needs of local communities. The HWB Chair noted:

*So it’s about developing that culture right through the organisation. Right down to the frontline, so that frontline staff feel safe that they can try something new, do something new. I said I’d like you to evidence it as you go along.*

**Site C:** interviewees shared other sites’ views of innovation being associated with doing things differently, but only when a need for change arose from recognising and understanding a need to improve. One interviewee observed that innovation within public health was not an absolute requirement as:

*most things that work well work because they’ve been tried before, not because they’re mad new ideas.*

Examples of innovation included service level projects targeting specific groups, and strategic, multi-agency initiatives where improving public health was only one of a range of proposed outcomes. However, like Site A, the VCSE sector interviewee in Site C also felt that there remained a willingness to support innovation by providing ‘some money and then we’ll see how it goes’.

**Site D:** interviewees reflecteda wider range of definitions of the concept of ‘innovation’ than some sites. Some viewed innovation as a distraction from ‘just getting the basics right’. However, others viewed innovation as a willingness to try something new, even though there may be a risk of failure. These voices often linked innovation to a process of moving from pockets of excellence to population change, encouraging communities and individuals to take responsibility for their health and to do the things that will support them to do that. Examples of innovation included single service projects and multi-agency initiatives.

**Site E:** interviewees placed more emphasis on innovation needing to grow from community engagement than some sites. One interviewee summed this up as:

*starting with the user …. Because you have to see things from the perspective of the individual.*

It was felt that this approach would automatically lead to multi-disciplinary and multi-agency solutions. This view was reflected in responses to questions about incentives for innovation and encouragement of public health outcomes. One interviewee spoke of the incentive being:

*a very dynamic conversation going between the politicians and the officers about how best to use the resource in a way that gets the public attention that tells a good story about how things are improving.*

Interviewees spoke of the need to start with non-experts in order to find new answers, with one reflecting that public health was now better placed to do this as local government was less resistant to changing established systems:

*…. And as a result of that I think local government has found innovative ways of delivering more for less and I think there’s a lot to learn within the NHS.*

**Site F:** theneed for innovation to support communities to identify and find solutions for themselves, in order to meet currently unmet needs and support self-reliance, featured strongly in Site F’s definitions of innovation. Examples of innovation included projects targeted at large populations or even the whole community.

**Site G**: there wasgreater divergence of response to the question of how to define innovation amongst interviewees than in other case study sites. Some statutory sector interviewees were cautious of giving any response, suggesting that the question was itself an attempt for the researchers and funder to look for good news.

However, other statutory sector interviewees, including the DPH, welcomed the suggestion that public health reforms should be associated with concepts of innovation. Interviewees made references to innovation being associated with adding value, getting value for money and improving lives, along with motivating communities and individuals to take control of their health, rather than expecting public services to do so for them. One summarised these views with the comment that:

*The whole point, for me, of being in the council is around innovation.*

Examples of positive innovative work that had occurred since the reforms were based on partnership work, either between local authority departments or at a multi-agency level, including work to tackle domestic violence, promote smoke-free public places and open-access play.

**Site H:** some interviewees shared ambivalence towards the term ‘innovation’ that was expressed in other sample sites; namely that ‘public health is about keeping people healthy. There is nothing radical about that’. In contrast to this view that public health would be improved by implementing what is already known to work, other interviewees expressed a view, also shared in other sites, that innovation required action. It was felt that the move into local government had provided an impetus for this to happen, whereas:

*in the old world public health was all theory, articulate great ideas, but then move on to the next great idea without implementing and seeing it through to delivery.*

Local government interviewees felt that the local authority had a cultural approach of being ‘about action, not bureaucracy’, with opportunities for involvement by everyone from volunteers to senior decision-makers. As a result of the reforms, public health specialists now had:

*an opportunity to directly influence the thinking and debate of politicians and very senior managers across a diverse range of services in local government.*

However, it was also observed that this new opportunity to influence also brought with it responsibility:

*ownership and seeing things through and that's been very powerful .... great ideas and new insights have been brought to bear.*

Statutory sector interviewees from Site H also made reference to financial limitations within local government, reflecting that this was not something new but had been the case for decades. It was felt that, as a result, innovation had also become embedded into the culture:

*We need to make savings, a million pounds, two million pounds, and that’s [been] happening for many ... years. But I think the last five years was very difficult, very difficult. And I think every local authority and everybody is thinking about it. What is the best way forward to deliver the most effective more efficient services? Having more innovation in the local authority, or even in the third sector. We are all looking at what is the best way forward to delivering more effective, more efficient services.*

**Site I:** when defining innovation, interviewees echoed others’ references to innovation being something new, but also acted upon. A strong emphasis was also placed on the importance of innovative projects being set up in a way that would enable evaluation in order to measure outcome, with one interviewee observing that:

[*we] don't have an innovation problem; we have an evaluation problem.*

Examples of innovation included participation in national-level multi-agency campaigns to target specific areas of concern, such as sugar intake. Non-statutory interviewees also made reference to small grants to VCSE sector groups to trial ideas.

Some non-statutory sector interviewees felt that there was a greater willingness to be innovative following the reforms. However, this view was not shared by all non-statutory interviewees. Others felt that opportunities for innovation had decreased as a result of the reforms, partly because of changes in commissioning relationships which treated the VCSE sector ‘the same as [a] private provider, tendering to meet their outcomes’, and partly because of the damage caused to relationships between public health teams and VCSE sector staff during the transition period.

Similar to some other sites, an association was made between innovation and promoting self-reliance and responsibility for health. It was felt that the period of greater financial resources had led to ‘accidentally … promoting dependency, rather than promoting independence’, whereas now public health services were now ‘more sustainable, more affordable, and more appropriate every which way’.

**Site J:** a local government interviewee in Site J believed that ‘innovation’ needed to be considered in terms of strategic leadership:

*I think it's about people who value other people's expertise. Where we all come from different professions, if you all respect each other and bring that knowledge and expertise and ideas together, it can be a fantastic combination, but you need to be open to other ideas and views.*

Most examples of innovation were strategic-level initiatives, including management of organisational changes such as merging public health responsibilities with other community services, joint venture partnerships with the VCSE sector and multi-agency intelligence sharing, multi-agency and multi-sector initiatives, for example, to reduce fuel costs. Statutory sector interviewees spoke positively of a post-reform culture which encouraged partnership approaches to develop innovative solutions.

Interviewees went on to describe a change in approaches from ‘traditional services’ to improved targeting. However, this positive view was not shared by the VCSE sector interviewee who considered that public health was now focused entirely on financial measures and ‘not exploratory or innovative or growing public health’. Innovative council-led activities, such as a ‘community connectors’ scheme, were also described as ‘hanging on by a thread for funding’.

**4.1.6 Beyond a definitional approach**

Whilst direct questions over innovation were included in all research elements of the study, public health innovation also emerged from an analysis of interviews as a whole. In particular, was the relevance of a changed context for considering public health innovation. This derived from the change in location of public health teams, less central control with more local flexibility and the resulting increase in local public health influence and synergy with other local authority directors and with elected members. This was reflected in changes in how services were being recommissioned. Further details are included in the discussion of a framework for public health commissioning (sub-section 4.3).

**4.2 Levers for promoting and diffusing innovation**

**4.2.1 Charting and mapping innovation**

In sub-section 2.5 of this report we reviewed:

* Downward levers for innovation.
* Sideward levers for innovation.
* Upward levers for innovation.

We also described how these levers might apply to public health in the context of local government. In this section, we describe classes in relation to each lever theme which emerged from the analysis of interview data from our ten case study sites. As mentioned in sub-section 2.5, there is a degree of interconnectedness across these levers for innovation. There were instances where the focus of a class was common to more than one lever theme; for example, the class focused on ‘Children and Young People’ was found in both sideward levers for innovation and upward levers for innovation. Arguably, where all levers are aligned, the potential for innovation is enhanced, a point returned to in the discussion.

Mapping interview data against these levers identified differences in distribution of the type of levers highlighted by interviewees in different case study sites. There were also instances where interviewees from the same sample site had different or even opposing views on the source of leverage driving innovation, and so data were coded to more than one lever theme. In all but one site, analysis suggests that downward and sideward levers predominated: considering sites as a whole, downward levers were more commonly identified than sideward levers. In one site, sideward levers were more often identified than downward levers.

Classes are summarised below: sub-sections 4.2.2 to 4.4.4 provide a more detailed account.

***Classes – downward levers for innovation***

Classes that emerged from the interview analysis included the following:

* Strong system leadership, engaging partners outwith the local authority;
* Austerity driven;
* Strong leadership within the local authority;
* Contract innovation;
* Result of securing additional resources.

Of particular relevance was the impact of austerity, which often forced change in how services were to be delivered across a local system.

***Classes – sideward levers for innovation***

Partnerships and networks were cited as leading to innovation in the following areas:

* Population-based services;
* Children and young people services;
* ICT and data-sharing services;
* Crime prevention services;
* Mental health services;
* Older people services;
* Commissioning support services;
* Sexual health services.

***Classes – upward levers for innovation***

Classes which reflected upward levers for innovation were derived from interviewee descriptions of services developed in response to unmet needs in specific groups or in specific areas; voiced needs identified through co-commissioning (for a range of different groups); issues where there were complex and interrelated problems which demanded innovative solutions; and community-based engagement activities. There was a degree of overlap with sideward levers, as complex issues often required partnerships and networks in order to implement change. Identification of unmet need could require a proactive public health input, acting as an upward lever for innovation. Classes which emerged from the interview analysis included the following:

* Children and young people;
* People at risk of offending;
* BMER communities;
* Community of place;
* Other underserved groups who fail/choose not to access services.

Services developed in response to unmet need among people who use mental health services were also identified. However, these were also linked with one of the classes listed above, and so were not identified as a separate class.

**4.2.2 Downward levers for innovation**

Interviewees in all sample sites referred to downward levers for innovation with more references to downward levers than for sideward or upward levers. This could be interpreted as a sign of strong leadership, resulting in a ‘golden thread’ of innovation spreading from elected members and senior managers through to departments and communities. It could also be viewed as an indication of revolutionary or disruptive innovation; the result of leaders having to face the challenge of austerity.

***Strong system leadership, engaging partners outwith the local authority***

Local authorities are not only leaders of their internal service departments; they are whole system leaders, working in partnership with other agencies and stakeholders, ‘collectively searching for approaches than can deliver better-quality, safer care and improved health at a reduced cost’ (Fillingham and Weir 2014, p.3). Interviewees gave more examples of innovation arising from system leadership than from leadership that was focused within the local authority. The need to lead collaboratively was summed up by a HWB Chair, as follows:

*The big prize and the only game in town really for me is that integration of health and social care. Because that is a place where we can make outcomes better for people. We can deliver the service they want from us, and we can save a boat load of cash along the way.*

In another site, the CE described how Council-led support for locality hubs had resulted in the development of a wide range of services including ‘health, council, police, neighbourhood … GPs’. It was emphasised that although the hubs were multi-agency, they were ‘about action, not bureaucracy’.

A further site had developed a strong partnership with a local prison, acknowledging both its responsibility for the health and wellbeing of the prison population and the health impacts of release and re-offending on the health and wellbeing of the wider community. This leadership had supported the development of a number of innovative partnerships at the service level.

In one site, innovation in public health was supported in part through a Council-level focus on managed economic growth. The DPH recognised that there were examples of past developments which had detrimental impacts on populations, and there was a danger that proposed transport developments, for example, could also have detrimental effects. Consequently, it had been agreed at a Council level that there would be health impact assessments on proposed work so that ‘it’s economic growth, but in a managed way that secured not only the economic benefits, but also maximises some of the health and wellbeing benefits’.

In a further site, a strategic partnership between the local authority and a major electricity provider had resulted in opportunities for residents to make savings on their heating bills. It was believed that this would have significant benefits for those most at risk of suffering the effects of fuel poverty and related poor health.

Interviewees varied in their opinion of how a Council’s view of the VCSE sector and consequent willingness to lead collaboratively with the third sector affected innovation. In one site, the VCSE sector interviewee believed that the local authority at a Council level was willing to view the VCSE sector as a collaborative leader, giving small grants to test innovative ideas and sharing facilities, due to a view that ‘we’re all working together’. A further site also showed some commitment to recognising the innovation potential of the VCSE sector through the awarding of small grants, but the VCSE sector interviewees in two other sites both felt that Council level decisions on commissioning processes had presented barriers to the VCSE and consequently reduced opportunities for the sector to be leaders of innovation.

In one site there was a ‘golden thread’, where the strong area-based leadership provided a ‘downward’ lever which fed through to ‘sideward’ and ‘upward’ levers of innovation. In this site, the local authority had made a Council-level decision to reduce funding to the VCSE sector and to adopt a community assets approach. This was translated at a service level to intra - and extra-authority partnerships leading to innovative services to address general population wellbeing. At a community level, it had supported upward levers which had resulted in place and need-based innovative projects. However, achieving innovation through strong area-based leadership appeared more difficult when the local authority was part of a much larger conurbation. In such a site, interviewees spoke of innovation being created by communities of interest and identity rather than communities of place, and in large conurbations, communities of interest may be dispersed across a number of local authority areas. As this site was part of a large conurbation, one interviewee felt that whilst public health did ‘lots of stuff, grant giving, social thing’, this did not necessarily stimulate local community enterprise. It was noted that:

*it's the difference between dyslexics in [local authority area], or dyslexics in [whole conurbation]. You know, you're not going to have different groups from all over [conurbation] all setting up and all being supported by their council. It's just ineffective. You're much more likely because [conurbation] is a community of non-places as much as it's a community of places, you know, community of identity and people want to get part of it and they want to get involved in social action around that.*

Possibly as a consequence of this, three innovative projects in this site arose from leadership which was pan-conurbation, including a pan-conurbation sexual health service and pan-conurbation projects to address childhood obesity.

***Austerity***

Austerity and the need to meet imposed cuts to finance were also frequently mentioned levers for innovation. In some sites, they were mentioned by both local authority and partner organisations. Austerity was viewed as an impetus for developing community assets and promoting personal responsibility, and moving away from what some viewed as a traditional public health response. A service director in one site spoke of the local authority recognising that ‘it needs to deliver things differently’ and creating a substantial fund for ‘the community to come forward on its own terms with some ideas that might help’. These would be evaluated and, if successful, the local authority would either commission the services ‘or let them carry on because they’ve been in power to deliver’.

A DPH in a different site believed that:

*accidentally in the past we were doing a bit of promoting dependency, rather than promoting independence, so the offer we made and the expectation of the public was ‘if I have some sort of health-related problem, I come to some sort of health-related sector and they will provide for me’. We're giving responsibility back to them. And quite often I think they may be more sustainable, more affordable, and more appropriate every which way. I think it’s actually a good thing. So move more, eat less, you know, if you’re overweight. Get a Labrador! Get a life!*

However, some interviewees, including some in the same site as interviewees who viewed austerity as a positive lever, felt that austerity had not driven innovation. In one site, the DPH spoke of pilot studies now being ‘a bit of a luxury’, the Healthwatch interviewee spoke of ‘very innovative and very successful’ schemes not being sustained’, and an elected member spoke of HWB discussions on innovative proposals facing a barrier because of some politicians’ view that ‘our budget’s been cut so we can’t do it’. Similar views were expressed from interviewees in two further sites. Notably, there was a difference in view between VCSE sector interviewees. The VCSE sector interviewee in one site felt that austerity and the consequent requirement to re-tender led them to:

*evaluate and look at how you deliver that service to try to fit their needs, and thereby there is no doubt that a lot of those services who have been successful will have had to be innovative.*

In contrast to this, the VCSE sector interviewee in a different site felt that the local authority was ‘running to us because they think that voluntary services are free services that can fill the gaps’, but that there was no respect for the VCSE sector and they were ‘seen as amateurs in delivering what’s required’.

***Strong leadership within the local authority***

For some interviewees, innovation was viewed as a result of strong leadership focused within local authority services and operations. This included strong leadership from elected members which facilitated opportunities for cross-directorate innovation.

Sometimes innovation was reported to have occurred simply from reorganising management structures and responsibilities. In one site, responsibility for public health commissioning had been placed with a director other than the DPH. The DPH described this as innovative and ‘quite exciting. We’re sort of looking at the issues and doing it as we go’. Strong leadership within some local authorities had nurtured a culture that led to an approach to innovation which could be traced through to department level. For example, in one site, strategic leadership introducing community hubs and promoting the national ‘Making Every Contact Count’ initiative had supported partnership-based service level innovation such as the early years’ family nurse partnership, domestic abuse partnership and proposals for using the fire and rescue service to deliver the prevention agenda. In another site, the CE believed that the public health reforms had given ‘ownership and seeing things through, and that’s been very powerful … great ideas and new insights have been brought to bear’. This was reflected in service level partnership-based innovations such as locality-based hubs and service delivery agreements across directorates to promote public health outcomes.

There were examples of public health teams being dispersed across the authority, with some public health consultants also based with the CCGs whilst still being managed by the local authority. A HWB chair described the dispersal as a deliberate decision to support public health ‘infiltrating and influencing different departments’. The DPH in this site was cautious of using the term ‘innovation’ to describe consequent achievements, but believed that the public health team had ‘created fabulous relationships’ with services concerned with transport, air quality, housing, planning and licensing, consequently ‘adding value on to other roles of the council, which we didn’t do before’. A service director in the same site spoke of public health staff being ‘well regarded’ and observed that the DPH ‘chose tactically to stay at the civic centre to be near the chief executive and I guess the hot democracy and closer to members’. (This could be viewed as the DPH acting as both a public and an empowered champion of innovation, deliberately taking action to secure sponsorship from political leaders and exerting upward as well as sideward leverage for innovation).

Whilst strong internal leadership, especially by elected members, was viewed as a lever for innovation by some, there were examples of such leadership being viewed as a barrier to innovation, with some elected members being unwilling to take risks or ‘go with a hunch’. For example, the NHSE interviewee for one site believed that elected members’ concern with meeting financial targets over-rode their interest in innovation:

*you sometimes get that real barrier from the politicians which is well our budget's been cut so we can't do it. So it's in some respects a kind of conversation stopper.*

In a different site, the DPH spoke of the difficulty of operating ‘when you’re not getting much support or buy-in from around you’, concluding that:

*it’s quite an uncomfortable place to be in, and if you don’t, and if it backfires on you and if you make yourself too unpopular then you completely cease to be heard. And then you’ve lost any opportunity.*

In one site, the VCSE sector interviewee believed that local authority officers in leadership positions also posed a barrier to innovation. The interviewee described a ‘wodge of staff in the middle, it's almost like their jobs depend on them being set in their ways’. In these examples, internal leadership was strong, but the resulting cultures were not conducive to innovation as there was no sponsorship.

***Contract-based innovation***

‘Contract innovation’ was classed separately from downward lever classes associated with system leadership or local authority-focused leadership, because the innovation resulted from contract requirements and strategies rather than public health-focused requirements and strategies. Some examples of contract-based innovation were the result of local authorities opening services to competitive tendering and requiring targeted outputs, such as in one site where wellbeing services were now being delivered by a consortium of voluntary organisations. In another example, a smoking cessation contract delivered by GPs now included a requirement to improve uptake of the service. Specification, outcome measurement and value for money elements of local authority procurement processes were highlighted by some interviewees. There were also examples of contract-based innovation where the procurement process was less rigid. In one site, the VCSE sector interviewee spoke of the local authority being prepared to give them ‘some money and then we’ll see how it goes’.

As with discussions on internal leadership as a lever for innovation, there were interviewees who felt that procurement processes hindered innovation rather than supported it. In particular, some VCSE sector interviewees found the competitive commissioning processes inflexible, limiting or even prohibiting VCSE sector involvement. The VCSE sector interviewee for one site reflected that as a result:

*some of the innovation and some of the opportunity to put in our ideas has been lost. We are basically the same as [a] private provider, tendering to meet their outcomes.*

However, the VCSE sector interviewee in a different site, an area where local authority funding for many third sector organisations had been stopped completely, believed that notwithstanding the demands inherent in the competitive tendering process, the requirement to compete promoted innovation:

*when you’re getting grants year on year, there’s not the necessity to be innovative. When you’ve got a position whereby you’ve got to try to apply, it makes you evaluate and look at how you deliver that service to try to fit their needs.*

***Innovation resulting from securing additional resources***

Two interviewees spoke of opportunities for innovation arising from successfully securing additional resources.

In one site, it was reported that the local authority as a whole had experience of securing additional external resources to support innovation. A service director described the local authority as ‘brilliant at getting pots of money for innovation’, and went on to describe projects which had public health benefits but also supported other objectives, such as developing small businesses or supporting digital inclusion. As the local authority had an established expertise in identifying and securing additional resources to support innovation, the continuation of such opportunities appeared more likely than in sites where expertise in identifying and securing additional resources for innovation was not mentioned at all.

The second example of innovation resulting from securing additional resources was time specific: at the time when the public health budget was being transferred one DPH found ‘that gave us a little window of innovation opportunity’. The resources had been used to fund a range of innovative projects, such as a basketball club and an interactive online drama for young people. However, as this ‘window of innovation opportunity’ had now passed, it seemed unlikely that further additional resources would be forthcoming without the combination of whole authority level expertise in identifying and securing additional resources and elected member sponsorship for public health innovation.

**4.2.3 Sideward levers for innovation**

Partnerships, alliances or networks were a common trigger for innovation, although as discussed above, this was usually combined with sponsorship from political leaders (downward levers). This reflected the view of many interviewees that public health reforms had increased opportunities for partnership working.

***Partnerships with a ‘general population’ focus***

Most examples of innovation were for services for the general population. Some arose from alliances with organisations which were already established partners, such as in one site where a public health consultant had been based with each CCG, leading to ‘really creative’ work on social prescribing’ (HWB Chair). There were also examples of new partnerships being built with other local government services, such as one site where housing services had been reconfigured so that support services including mental health and other specialist services could be delivered at a community level throughout the area. Similarly, in a further site, partnership work between public health, community protection, licensing and events management had led to an increase in smoke-free public places. The DPH in one site had responsibility for the leisure service commissioning budget, which had provided an opportunity to ‘rebrand … the whole of the leisure offer’. Public health now worked in partnership with leisure services, parks and open spaces to deliver a year-round programme of events aimed at increasing activity levels amongst the whole population.

New partnerships had also been established with other statutory sector organisations. The fire and rescue service was a partner in three sites, leading to fire and rescue service home safety visits being expanded to be ‘much more holistic … they can liaise with other people within the authority … also giving out the public health messages’ (HWB Chair). One of the two-tier case study sites had developed a partnership with District Councils to deliver exercise programmes through health champions working ‘at a local level to give direction on lifestyle choices, as far as exercise and food’s concerned’ (HWB Chair). In a further site, locality-based information hubs were being delivered through partnerships with a range of other agencies, and this site was also involved in piloting an initiative to improve adult health, working in partnership with four national voluntary organisations and the CCG.

Partnerships to deliver public health services had been developed with the private sector, such as one site where a national supermarket chain had been used as a base for delivering health checks (although this service was subsequently discontinued).

Three sites provided examples of innovation arising through partnerships with the VCSE sector, although the nature of these partnerships varied. In one site, partnership was based on a formal contract, with wellbeing services now delivered through a VCSE sector consortium. The DPH described this as:

*not an ongoing service for individuals; it’s about picking people up in certain circumstances and supporting them for a limited period of time, six to eight weeks, to get them in … . So it’s about not putting ourselves in a position where we have an ever increasing number of people who we have to provide low level services to; it’s about helping people to get to a position where they can maintain themselves for at least a while.*

However, another innovation arising from partnership with the VCSE sector was focused on utilising volunteers as health messengers and role models. The VCSE sector provided a free county-wide training programme for anyone undertaking voluntary work who wished to learn new skills. The training course comprised aspects of good volunteering, such as customer care and equality and diversity.

However, the training also had a section providing knowledge of key health messages and awareness of signposting and referral options. It was believed that engaging with the area’s entire volunteer workforce would provide avenues for communicating health messages across the whole community, including into groups who were often very difficult for traditional public health services to reach. In a second site, a partnership with the VCSE sector had led to VCSE sector organisations being based in and delivering services from local authority community buildings, such as libraries.

Although there may be examples of this type of partnership in other areas, it was new for this area, and was leading to improved community engagement and take-up of services.

***Partnerships to deliver Children and Young People services***

Many partnerships and alliances were based on a shared focus on particular groups and communities of interest, identity or faith. Most of these were partnerships focused on supporting children and young people, particularly in areas of child protection. For example, a service director in one site described a multi-agency initiative to improve fostering services. Partnerships with local employers had led to agreement that employees who fostered children ‘could have time off in the same way you would have with the birth of a child, when you’ve got a new child into your care, you’d have time off to attend meetings with social workers’. The interviewee spoke of how this led to improved health outcomes for children ’that’s not about spending money; it’s about creating relationships and creating ambition’. In another site, a partnership approach had led to early years’ support, including family nurse partnerships, health visiting and Sure Start all being provided ‘under one roof’. The HWB Chair believed that this had resulted in ‘all the pieces of the puzzle for early years’ support’ being brought together, leading to ‘critical’ benefits. A further site also reported innovative approaches arising from partnerships between public health and the school nursing service.

There were also examples of partnership approaches to tackling childhood obesity and achieving a healthy weight. Some operated at a local authority level such as in one site, which had undertaken a range of public health projects in schools, including organising ‘sugar debates’ by groups of children and young people, or as in another site, through working in partnership with national campaigns such as ‘Food Dudes’[[1]](#footnote-1) and ‘Henry[[2]](#footnote-2)’. One site gave an example of a partnership with a range of sectors, including local retailers, large-scale employers and health services to promote sugar intake reduction amongst children and families. Other examples of partnerships focused on supporting children and young people included a site which had introduced ‘a number of provisional instructional measures’ built into the policy and planning processes. These measures required all local authority and strategic partners such as the police, utilities and retail sector, to show ‘how would you make it better?’ for children and young people (service director). This had been shown to be a:

*very powerful way into changing some health outcomes that’s not about spending money; it’s about creating relationships and creating ambition.*

Finally, one site reported a partnership project to address the high level of children being admitted into hospital with respiratory difficulties. The partnership involved public health, children’s services, the CCG and a local radio station. The service director described a ‘flashy bus with flashing lights and music’, travelling to the centre of housing estates to deliver information and other services, with the aim of achieving behaviour change and improving management of these conditions by parents and their children.

***Partnerships concerned with ICT and data-sharing services***

There was innovation arising from ICT-focused partnerships, again possibly reflecting interviewees’ responses, noted in Research Report 5, about the benefits of public health moving into local government. Sites reported data-sharing arrangements, such as one site which reported a ‘Big Data’ project; a multi-agency project sharing live performance data which practitioners could access from their desktops[[3]](#footnote-3). A further site also spoke of a data-sharing partnership, where data from health checks were shared in order to identify people at risk of cardiovascular disease (CVD) but not on the CVD register. One site described establishing a joint health intelligence unit with a neighbouring local authority and associated CCGs.

There were also reports of innovative collaborations to make use of ICT to support public health outcomes. As a local authority, one site had ‘innovation hubs’ (service director), which brought together staff, service users and ‘clever techie’ people to develop innovative solutions. Examples of innovation arising from this approach included a ‘little traffic light beacon’ for people with limited mobility to use in their homes which indicated when a bus was due to arrive and how long it would take to walk to the bus stop, and an online questionnaire which helped disabled people make choices of where to live. A further site had invested in an interactive online drama (see sub-section 4.3 for further details).

Another site had invested in an online counselling service for children and young people. A service director reported that the:

*Cost is miniscule, touches the lives of thousands and thousands of young people. They find it really accessible, they communicate on the internet, that’s how they engage. And it’s a really creative, accessible service that is really well used by individuals.*

Others gave examples of recognising changing preferences and using existing ICT to deliver traditional services, such as one site which used Facetime[[4]](#footnote-4) to deliver health visitor services in rural areas.

***Partnerships concerned with victims of crime and/or people at risk of offending***

There were examples of innovative partnerships established to address the health needs of people who are victims of crime and/or people at risk of offending. Some of these had a strong mental health dimension. For example, one site had developed an innovative partnership with the CCG and police, which involved mental health social workers being based in police stations to assess and support people with mental health needs. This had resulted in a significant drop in the number of people with mental health needs being held in police cells inappropriately, and it had been recognised as an example of good practice at a national level. Another site had worked in partnership with a prison to address drug and alcohol abuse and suicide prevention. A further site had worked in partnership with licensing services and the police to tackle tobacco control and illicit sales, which was viewed as a new approach for this site, moving away from ‘your traditional smoking cessation’ (NHSE interviewee). Two sites highlighted their partnership approach when planning domestic abuse services. One of these sites held cross-council monthly public health forums on particular areas of interest, and the forums on domestic violence had been ‘incredibly popular’ (DPH), generating interest from partners and stakeholders.

***Partnerships delivering mental health services and support***

As already described, many partnership-based innovations supported good mental health as well as other outcomes. One site also gave an example of innovative preventive work led by public health to support people with very limited incomes to manage their finances and avoid debt, through working in partnership with welfare benefits advisors and credit unions.

***Partnerships supporting older people***

Innovative partnership approaches to meeting the needs of older people were also mentioned. Some examples were of partnerships providing direct finance for innovative solutions, such as one site where the DPH mentioned a £3m Adult Health Care fund for pump priming ‘spend to save’ initiatives. Other examples were of partnerships with the VCSE sector to deliver services. In a further site, voluntary organisations were organising tea dances, and delivering advice and practical help as part of a ‘keeping warm in winter’ project. Neither of these may be new, but delivering them through voluntary organisations, which had a different relationship with older people than public health professionals, was innovative for this area and was achieving improved outcomes.

***Supporting partners to commission services***

Research Report 5 reports interviewees’ views that a positive outcome of the public health reforms had been opportunities to benefit from local government commissioning expertise and infrastructure. In one site, the DPH noted their appreciation of the move to local government which had allowed an alliance to be formed with a ‘very good procurement lawyer’ who was able to do ‘very innovative things with contracts’. They went on to compare this with their previous experience where this was ‘not the NHS’s forte’. The benefits of sharing expertise when developing commissioning were balanced between partners. In a further site, the DPH believed that public health staff were giving practical help for the design and evaluation of innovative approaches proposed by other partners so that:

*they catch all the right before and after data. Much more commonly is someone's had a bright idea. They've implemented it. It's run for three years and they then say can you evaluate that now?*

Public health staff could offer expertise in planning how to evaluate innovative projects before they started. This was important if the proposed innovation was to meet the criteria of not just being new or achieving a better outcome, but of having evidence of this.

However, the Healthwatch interviewee in this site felt that this partnership did not encourage innovation, stating that public health had been dismissive of their suggestions because Healthwatch are:

*not academic researchers. And they don't like anything that isn't. And they've just been really, really sniffy about everything we do.*

For this interviewee, rather than public health expertise providing a lever to support innovation in commissioning, it presented a barrier to risk-based innovation.

***Sexual health partnership-based services***

One site was involved in a partnership with neighbouring local authorities and health services to deliver sexual health services. Although it was too early to have strong evidence of success, the service director felt that it was a ‘good example’ of innovative partnership working, because sexual health was a very complex area and it was difficult to judge on a local level whether a drop in clinic attendance was an indication of success or simply the result of people obtaining services elsewhere.

**4.2.4 Upward levers for innovation**

When reflecting on advantages arising from the public health reforms, many interviewees expressed a view that addressing health inequalities was not possible without greater community engagement. They spoke of the reforms leading to public health services being more in touch with local communities, and of increased opportunities for co-production and co-design (Research Report 5 refers and see sub-section 4.3). However, when considering levers for innovation, communities of place and communities of interest, identity and/or faith had less influence than downward or sideward levers. Although case study analysis is qualitative, not quantitative research, it is notable that during interviews, interviewees from some sites made no reference to innovation arising from leverage exerted by community groups. This may simply reflect the fact that demands for improvements in health services predominate. Meeting the needs of underserved groups and addressing health inequalities therefore tends to emerge from local authorities and their public health teams fulfilling their public health responsibilities. This can be encouraged through close working at ward level between public health teams and elected members, evident in some of our sites.

***Children and young people***

The most frequently mentioned examples of innovation were those arising from leverage exerted by children and young people. Some of these services had been developed as a direct result of public health and their partners adopting principles of co-design and working with young people to gather their ideas, such as the idea of people dressing up as angels and distributing water in night-clubs to counter the effects of drug or alcohol use, which the young people felt would be more effective than existing arrangements because it was humorous and non-judgmental. An interviewee noted that ‘the police love it. The bars love it. And it's evaluated extremely well’.

Other services were innovative for a particular sample site, but were based on evidence of success in other geographic areas, such as a basketball court or a street dance project, where the leverage arose from young people choosing not to engage with other services aimed at encouraging exercise. Finally, there were examples of innovation which arose from service providers understanding and responding to the characteristics and preferences of young people, such as the online mental health service in one site which proved a popular means of service delivery for young people, many of whom might not have sought to engage with a traditional face-to-face service. This model of service delivery may not be appropriate for mental health service users from other age groups, but it did match the known access preferences of young people currently not engaging with a counselling service, and possibly not even being offered a service.

***People at risk of offending***

Other innovative initiatives, some already described, were developed through co-design to support both people who were at risk of the results of crime or at risk of offending, both of which have negative impacts on physical and mental health and wellbeing. These included a review of substance misuse services in one site, which involved service user representatives and informed the tender of the prime provider contract, resulting in improved outcomes.

***BMER communities***

There was an example of innovation arising from leverage by BMER communities. In one site, research had been carried out with community organisations and 500 residents as part of a review of hepatitis B/C among BMER communities. This had raised awareness of the needs and preferences of this community among health professionals as well as among community members, and had led to improved outcomes for public health services relating to liver disease.

***Communities of place***

There were examples of innovation arising through working with communities of place. For example, one site had reconfigured its housing support services, recognising that ‘it’s more important to deliver those [specialist services] close to where people live and where they need those services’ (HWB Chair), and consequently engaging more people than had been the case when services had been delivered in specialist centres, possibly a long way from where people lived. Another site held annual HWB ‘listening events’ at local community level, and the outcome of these fed into locality-based commissioning strategies and working models.

A further site had a number of examples of innovation which arose though adopting a community assets strategy, ‘developing and utilising community interest companies and social enterprise’ (HWB Chair). Rather than closing a leisure centre which was operating at a loss, public consultation and engagement had led to the transfer of ownership of a leisure centre from the local authority to a trust, resulting in the centre now operating at a ‘small surplus’ (service director). Innovation arising from this approach also included ‘community of interest’ initiatives, but developed at a local community level. These included the development of a community-run drumming group as a focus for support, socialising and stress release for people with mental health needs, a community enterprise fisheries project which provided exercise, mental health benefits and diversionary activities for young people at risk of offending, and a project which aimed to address food poverty.

***Other underserved groups who fail or choose not to access services***

Finally, there were examples of innovation arising from leverage from other identifiable groups who were not engaging fully with preventive services in their current service mode. These presented a lever for innovation as they ‘forced’ public health to consider new ways of working in order to achieve its goals. For example, one site had offered health checks at main supermarkets and a further site was offering health checks outside football grounds in order to engage people who had chosen not to take up opportunities to receive health checks through their GP. Such initiatives were not innovative *per se* but could be new for specific sites. As mentioned above, a site was offering health visitor services through Facetime rather than only through home visits in order to make more frequent contact with mothers living in rural areas who might otherwise be isolated from services and so be unable, or choose not, to use them. The further development of such options reflected acceptance that the existing service delivery arrangements did not recognise the other preferences and pressures existing in people’s lives, and an increased willingness by public health to adapt to these.

This sub-section has summarised different pressures and levers for innovation. The following sub-section illustrates projects related to eleven themes related to public health commissioning. The extent to which innovation in public health commissioning occurs partly depends on how these levers are aligned, how initiatives and approaches are applied to a framework for public health commissioning and how this is translated into a local context. These points are returned to in the discussion section.

## 4.3 An innovation framework for public health commissioning

**4.3.1 Introduction**

The research proposal identified the importance of developing an ‘innovation framework for public health commissioning’ in order to support future relevance of the research. The previous sub-section reviewed initiatives in the context of three levers for innovation. The focus of this sub-section reflects proximal enabling factors arising from the reforms and which may apply, in combination, to many preventive initiatives. These enabling factors include procurement expertise in local authorities, co-location of public health and other local authority staff, the potential for greater involvement across council directorates and the local government infrastructure for community engagement and for co-commissioning which can now be applied to public health services transferred from the NHS. As mentioned in the previous section, there is also further development of online services related to mental health, sexual health, including using apps for sport, and use of Facetime by health visitors and of Skype for alcohol support. Other potential enabling factors were increased use of the Social Value Act and of Social Impact Bonds.

This sub-section draws on views of both interviewees and survey respondents in order to develop a public health commissioning framework, illustrated by examples raised during the research process. It focuses on research themes highlighted in the research proposal, namely innovation in the provider landscape and in service delivery, in co-commissioning, community engagement and targeting, with particular emphasis on healthy lifestyle services and addressing child obesity.

Examples of innovation were identified from different elements of the study, i.e., from two national surveys of DPH and CCG members of HWBs, the national survey of VCSE sector organisations, the national survey of local Healthwatch and VCSE sector members of HWBs, and from a range of interviewees in the ten case study sites. Examples suggested by interviewees were supplemented by documentary analysis, where possible. As mentioned in sub-section 4.1, not all respondents offered definitions or examples and the concept of innovation was sometimes contested. Evidence of innovation since the public health reforms was questioned, sometimes because it was argued that innovative approaches pre-dated the reforms, so that a commitment of innovation represented a continuation rather than a change in approach. In other cases, interviewees commented that projects were not innovative in the sense of being completely original, but that they were implementing good practice from elsewhere or ‘implementing at scale’. A project could be considered innovative if it was new in a specific context or for a specific local authority.

As described in sub-section 2.8, there are already frameworks for summarising public health functions and outcomes and each element of these frameworks may be associated with innovation in commissioning: this section is limited to innovation identified in the study in the context of the new public health responsibilities of local authorities and the changed organisational arrangements for public health teams. It is, therefore, partly contextual and is not intended as a comprehensive assessment of sources of innovation in public health. As a snapshot in time, some of the projects identified may have been discontinued since interviews and surveys were carried out.

Whilst some of the examples below emerged as a result of direct questions in the surveys or interviews, examples of innovation arising from the reforms also arose through analysis of the data as a whole. For example, interviewees described how the co-location of public health and other local authority staff had itself led to a synergy of approaches and to the greater influence of public health teams on a range of services. VCSE sector respondents to the survey demonstrated that their definition of preventive projects often incorporated holistic approaches and a concern with mental health issues and vulnerable groups. These topics are included in the framework, in addition to themes already identified through the research proposal. In the paragraphs below, themes which emerge from the analysis are illustrated by specific projects.

**4.3.2 Innovation illustrated**

Examples of projects and initiatives are provided for eleven key themes related to public health commissioning. These are illustrative only. A summary of all projects highlighted by interviewees is included in Appendix 1.

***New services commissioned through public health teams***

There was a spectrum of responsibilities held by public health teams for services which had traditionally been provided solely by local authorities. As described in Research Report 5, this could be organised through a separate public health directorate with additional formal responsibilities or through deployment of public health staff across different directorates. In one site, a public health directorate held responsibility for functions including community engagement, management of the housing revenue fund, management of telecare services, libraries (also used as community hubs) and preventive elements of the Care Act. In another site, leisure services were the responsibility of the DPH (although public health was not a separate directorate in this case).

These new responsibilities had the potential for extending a public health perspective across traditional local authority functions and services. A public health perspective could also be reflected in training responsibilities. This was evident in one site, for example, where planning was in place for public health representatives to deliver training to newly qualified social workers, to give them a comprehensive understanding of public health and key roles within it.

*Example: Social fund and community care grants managed by public health lead to improvements*

Prior to the reforms, responsibility for Social Fund Crisis Loans had been transferred to local government from the Department for Work and Pensions. Responsibility was initially held by a service director (social care), but it was now held by public health ‘because of their capacity’. The contract for issuing crisis loans had been awarded to a credit union, which was able to give advice on reducing debt in order to reduce the need for crisis loans. A partnership with another VCSE sector organisation was also established to provide recycled furniture and equipment. The new arrangement reduced the cost of the service by 20%, as well as improving outcomes related to physical and mental wellbeing and environmental impacts.

***Public health skills in health needs assessments and data analysis contributing to targeting and mapping across directorates***

As described in Research Report 5, many interviewees highlighted the contribution of public health skills in marshalling evidence, data analysis and health needs assessment. Some public health teams had focused on detailed ward-based analyses working with elected members, thus promoting local understanding and commitment to public health issues. These skills were now being applied to services over and above public health services, including children’s services, for example, where they were described as increasing the effectiveness of targeting. This was innovative in the sense that it could inject a new public health perspective into services traditionally provided through the local authority. As one interviewee noted:

*How can we put added value into what the council is already doing, with a public health hat on? And that is largely around what's the evidence base? What are the outcomes? How can we actually get more for our money? How can we help improve the lives of people through our contribution? So I think that is the innovation and it's happening everywhere across the council to a greater or lesser extent.*

There was more evidence across sites of such activity in services for vulnerable groups than for wider local authority services, although there were also some examples of public health analyses and perspectives being applied to planning and to the impact of concentrations of fast food outlets.

***Providing services through expanding the public health workforce***

Whilst sites often reported a decline in the number of funded public health staff, they also reported methods for exploiting the public health potential of the wider local authority workforce. These included: education and training opportunities at different levels (including Masters in Public Health) for local authority staff and for pharmacy staff and dentists; adoption of ‘Making Every Contact Count’ for public health purposes, so that health-related advice and referral across local authority services could be provided by a range of staff, such as housing staff. This could be included in contracts with housing associations, for example. Interviewees also highlighted innovation in other local authorities, for example, using hairdressers to disseminate information on cervical screening and skin cancer.

*Example: Fire and rescue services for health improvement*

In three case study sites, fire and rescue service home safety checks had been further developed to identify wider health and care support needs and consequent referral on to wider public services. This opportunity arose partly because of a general reduction in demand for emergency response calls to fire and rescue services, and partly because of recognition that the fire and rescue service is a trusted profession which has respect amongst all age groups and communities. This collaboration led to identification of need, and consequent support being offered to vulnerable people who possibly would not have been identified through other targeting strategies, such as older people living in affluent areas who may be at risk of social isolation, fuel poverty or falls. There was, however, some difference of opinion amongst interviewees over this initiative if it fell outside the management of the public health team.

***Developing within directorate and cross-directorate approaches to improving health***

Promoting health considerations within and across directorates was not always innovative for the authorities concerned but a continuation of public health-related initiatives which pre-dated the reforms. The reforms were, however, perceived as legitimising and galvanising these approaches. There were initiatives designed to embed public health approaches within each directorate (sometimes explicitly associated with promoting a ‘Health in all Policies’ approach), examples of health impact assessments and of promoting public health perspectives in local authority plans, with examples from school meals services, licensing, planning, housing and leisure. There were also examples of public health service delivery agreements with other directorates, monitoring the use of funds transferred from the public health budget, although such plans were variously implemented. In some cases, there was action across directorates for a specific issue such as obesity. These initiatives further illustrate the potential of using agreements, strategies, contracts and legislation which fall within the remit of local government. Such initiatives often involved working with other partners towards a whole system approach.

*Example: a systematic approach to embedding public health in the work of all directorates*

In one site, a systematic approach had been adopted towards promoting a ‘Health in all Policies ‘ approach, through (1) establishing health impact assessment processes for all directorates, (2) a Social Determinants of Health Fund for a two-year period, allocated across directorates to enable action on health improvement and (3) public health delivery agreements with each directorate and portfolio holder to include five public health outcomes as ‘added value’ to their existing activity (as well as specific interventions agreed as part of the Social Determinants of Health Fund). The five additional outcomes would form part of mainstream activity and investment for the directorates concerned and would be chosen in line with local priorities and targets and with reference to the public health outcomes framework. Relevant directorates were mapped against specific health outcomes, thereby making agreed contributions by directorate more explicit.

*Example: a strategic and cross-directorate approach to addressing premature mortality*

In another site, there was an example of a strategic commitment across the local authority to address causes of premature mortality. The local Scrutiny Committee undertook a review to assess action being taken to address the main causes of premature mortality and assess effectiveness of existing interventions. The review took evidence from a wide range of expert witnesses, including from the NHS, VCSE sector and higher education sectors. Evidence was also taken from local authority departments involved with wider determinants of health, such as sports and leisure services and housing services. The review resulted in recommendations for action which have been included in the HWB programme of work, and continue to be monitored.

*Example: using legislative powers by directorate*

One site recognised that the local authority plans did not address health impacts associated with hot food takeaway shops but focused on managing and minimising environmental impacts such as noise, traffic, odour and refuse. To address this, the local authority undertook a review of the existing national, regional and local policy framework in relation to hot food takeaway shops, assessed both planning and health related issues around such establishments, and made recommendations on the future local management of hot food takeaway shops in the area. A subsequent plan (2014) included specific limitations on planning permission for new hot food takeaway shops. Planning permission would not be granted for new hot food takeaway shops within 400 metres of the boundary of a primary or secondary school. Also, the local authority would manage the concentration of takeaways in shopping areas. The plan in this site also took account of other priorities set out in the area’s JSNA. These included supporting sustainable development, promoting equitable access to quality housing, protecting local shopping areas to encourage walking and cycling and reduce car use, and promoting access to community facilities and services such as public conveniences, nurseries and childcare and places of worship.

*Example: directorates working through contracts with providers*

One site had worked through contracts for school meals, reducing sugar and combining this initiative with conversations in schools. The site had developed a sugar reduction programme based on five workstreams: ‘Change4Life’ events; public sector food procurement; young people and sugary drinks; sugar reduction champions; and healthy vending. The public health team took the lead on all workstreams, working closely with other partners within the local authority, including the catering service. The school meals service made gradual changes to menus, reducing sugar and portion size and increasing healthy desert options. Throughout this period, customer satisfaction remained high, with uptake rates of over 80%. Over the 20 months of the project, sugar in primary school meals was reduced by 41%, and there was also a measurable trend of pupils choosing fruit and yogurt rather than traditional sugary puddings. Sugar content is now one of the key performance indicators in the school meals supplier contract. The public health team also worked with a local district youth council to hold annual school debates to discuss the role of sugar. The event highlighted that many young people go to school without breakfast and consequently have sugary snacks as a substitute. This had led to the development of priority actions, such as increased messages for parents and professionals stressing the importance of breakfast and the extent of parental influence on habits.

***System-wide approaches for specific public health challenges***

Interviewees described a wide range of local authority involvement with other partners with the aim of improving health-related outcomes, although many such initiatives were well-established and not related to the reforms. Initiatives could be limited to health aspects of specific services (such as for domestic violence), involve collaboration over single public health-related issues, ranging from smoke-free public places (working through events management and playgrounds), to shisha bars (working with police and the VCSE sector), or reducing fat and salt in produce (working with local retailers).

A system-wide approach is recognised as fundamental to addressing complex, multi-factorial public health problems. Public health representatives were increasingly being involved in planning groups across directorates. In one site, public health was involved in planning groups for addressing smoke-free public places and in another in promoting ‘green parks and spaces’ within Leisure Services. In this example, the public health team also hosted monthly cross-council public health forums to discuss topics with opportunities for partnership delivery, such as for dementia services or sugar reduction. However, few sites had developed sustained multi-agency approaches to complex areas such as child obesity, as one example of a public health problem that requires action across a whole system.

*Example: a system-wide approach to addressing obesity*

One site had adopted a system-wide approach to tackling obesity. As well as services to promote healthy lifestyles, action was being taken to ‘change the environment’. This included political lobbying at a national level for the introduction of a sugar tax and working with local retailers to change practices such as displaying confectionery next to cash registers. It also included recognising that food purchase choices were influenced by cost, and for those experiencing poverty, low sugar, more healthy foods were often more expensive and so not affordable. Consequently, actions to maximise income through increasing employment or giving advice on welfare benefits were also part of the council-wide strategy to tackle obesity. The local authority became a ‘Sugar Smart’ area, supporting the Jamie Oliver and Sustain national Sugar Smart Campaign to raise awareness and reduce consumption of sugar across all age groups by promoting healthy alternatives and removing or reducing unhealthy food and drink. It also embraced the ‘Daily Mile’ initiative, with all primary schools encouraged to allow children in the school to run outdoors for twelve minutes each day. Finally, it took action to increase use of parks and open spaces. It explored use of social media and web-based technology to make it easier for people to use the parks for play and exercise, and it worked with higher education and VCSE sector organisations to provide organised recreational activities in parks, such as dance classes or basketball.

***Recommissioning preventive services***

In the announcement of the public health ring-fenced grants (2013-14 and 2014-15) the Secretary of State for Health noted that the public health grant would help 'transform the lives of local people through commissioning a wide range of innovative services’ (HC Deb, 10 January 2013, c21WS). Interviewees and survey respondents identified a wide range of preventive projects (summarised in Research Reports 3, 4, 5 and in appendices 1 and 2). In most case studies, preventive services inherited from the NHS had been reviewed and there were often changes to these services as they were recommissioned in line with local priorities, performance against key outcomes or to reflect changes in the evidence base.

Interviewees drew attention to services which reflected changes from traditional NHS-based commissioning. A wide range of models was being developed to bring together lifestyle services previously provided separately, linked into follow-on services, which sometimes included social prescribing. Changes reflected a holistic model, closer links with other local authority services (including children’s wellbeing, looked after children and domestic violence), more emphasis on social aspects, and co-production and peer support in services such as those for drugs and alcohol. There were changes in providers and in contracts with the latter including more detailed specifications and monitoring arrangements and an emphasis on cost-effectiveness. Interviewees from public health teams often commented on the different processes for contracting within local authorities, which were generally perceived as beneficial.

For drug and alcohol services, examples were provided ofservices being recommissioned in ways that were moving away from ‘professionally dependent' to more community-based models. An example of this was a recovery model for a drug and alcohol service where those in recovery volunteered to support the next group coming through, so **‘**you’re strengthening the approach of that whole community, and taking that forward’. Interviewees also described being able to recommission sexual health services which were more integrated, and co-produced. They were sometimes tied into the VCSE sector (with an example of VCSE sector support being funded through the CCG), increased use of online services (where a drop in demand had been demonstrated)and more community-based services. An interviewee commented:

*whereas before we had family planning very separate from genitourinary medicine services, different NHS trusts doing it. And now we’ve managed to integrate that, so women aren’t having to go to just one service and then go to another.*

In one site, a strategy had been approved (2016) which adopted a less clinical approach to weight management, replacing it with a multifaceted systems-based approach. This included a more upstream and family-based approach which was better targeted, a separate service for men, a combined approach (including behaviour change, physical activity and healthy eating) and funding for supporting a wider systems approach. This involved action from other council departments and partner organisations, including local businesses and schools.

This illustrates how innovation derives less from one innovative intervention than from combinations of approaches combined with a shift in emphasis.

***Example: integrating wellbeing services***

One site,which had high levels of deprivation, premature mortality, smoking and alcohol use and low levels of physical activity, had succeeded in bringing together and aligning different service elements within an integrated wellbeing service. This had the aim of providing an accessible service which could reduce premature mortality, multiple morbidity and social isolation and increase independence and quality of life. The service recognises the clustering of unhealthy behaviours and the limited role of behavioural interventions in improving the health of those who are most disadvantaged as well as the impact of deprivation on long-term conditions. The service succeeded in bringing together drug and alcohol services, a range of active living and health interventions, debt and welfare advice, housing and neighbourhood services. It also provides links to health trainers, volunteering opportunities and involves a range of partners from the statutory and the voluntary sectors. There is a single point of access via a wellbeing hub with advisers, also available through self-referral. Health professionals are the source of about half the referrals with self-referral amounting to about a quarter of referrals. Motivational interviewing is combined with shared decision-making with follow-up provided. This was described by an interviewee as a ‘well-used resource’ that brought together full lifestyle checks with other resources available in the council to reflect a ‘broader sense of wellbeing’.

***Example: family-based approaches to prevention***

Some case study sites adopted a ‘whole family’ approach to tackling childhood obesity. One site aimed to instil health messages from pre-birth, encouraging healthy eating in pregnancy, breastfeeding and encouraging physical activity through work with childminders and nurseries as well as traditional school nurse and health visitor services. There was also active engagement with other services to promote physical activity, such as through an activity programme commissioned by public health and delivered through a leisure trust, and through engagement with volunteer-run sports clubs. Another site had also adopted a partnership approach, working with a university to design and deliver activity programmes for families and young children. Partnerships had also been established with housing providers to ensure that open-access play opportunities were available to all children and young people, thereby promoting physical activity.

***Example: new approaches to drug and alcohol services***

Drug and alcohol services form a major part of the public health budget, and were often being recommissioned once inherited contractual arrangements had come to an end. In one case, an integrated model had been adopted through a change from a traditional drugs service (with one provider), an alcohol service (with a different VCSE sector provider), plus small contracts (with pharmacists), to a single integrated contract for substance misuse. In another site, the potential for linking across council services was identified as a shift from a traditional NHS approach to commissioning. An interviewee noted that:

*the other bit that we’ve really tried to take a note of is around the domestic violence part, and the criminal part. And again I think the new service just has much stronger links than we ever did before. To be frank with you I’m not convinced if we recommissioned that in the NHS we’d really have thought about those elements. But they were really important elements to the council. So the council’s got a big issue about looked after children, and drugs is an issue about the parents. So that’s been very helpful.*

The same interviewee commented that *‘So yes, the ethos of the services, they are different to what had gone on before’.*

There is greater emphasis on peer support, on the impact on children and also on community safety.

*Example: a recommissioned drugs and alcohol service*

In one site, a new Drug and Alcohol Strategy was developed in partnership through a multi-agency board which included the police, fire and rescue service, CCGs, probation, Safeguarding Children’s Board, and VCSE sector representatives. The strategy aimed to be holistic, linking with other strategies such as the Children and Young People’s Plan. This had led to a ‘Think Family’ approach so that when making a referral for drug or alcohol treatment services, consideration is given to the impact of the person’s condition on other family members. Where additional needs are identified, referrals are made to other support services where necessary. The local drug and alcohol service was recommissioned through a co-production model and partners across the voluntary and statutory sectors provide an integrated service. An interviewee commented:

*it was great to see a third sector-based organisation but with health service doctors there as part of it all. Fantastic, just quality was great to see. So it’s very inspiring and shows you can make a difference.*

***Commissioning through co-design and community engagement***

As described in Research Report 5, co-design of services as part of the commissioning process is well-established in local authorities. Public health teams are able to benefit from these links and, as mentioned earlier, there had been close involvement of public health teams in using co-design as part of the recommissioning process for services for sexual health, drugs and alcohol, domestic violence and for Child and Adolescent Mental Health Services. Engagement in the early stages of designing preventive services was reflected in one site, where over 100 organisations had engaged in a discussion over the future development of healthy lifestyles. In this case, prior to the reforms, lifestyle services had been delivered through a healthcare trust, comprising elements such as health trainers, smoking cessation services and mental health services. Before awarding a new contract, public health user segmentation analysis was carried out to identify population groups most in need of support.

A co-production approach was also taken in one site when reviewing existing VCSE sector contracts or services. For example, an event to consider future plans for BMER dementia services was attended by 200 people. Local Healthwatch also had specific engagement contracts in some sites and had developed engagement strategies for children and young people, for example, in addition to carrying out their mandate of providing a voice for seldom heard groups including asylum seekers and refugees. Use of technology was a key feature of co-design involving young people and there were examples of co-design of web-based services created and designed by young people and of an innovative interactive online drama, developed through co-design and subsequently made available nationally.

*Example: co-design in developing interactive resources*

An example of an innovative interactive online drama was cited which allowed young people to play the main character in the drama online with choice of outcomes filmed. This involved hundreds of young people with the scripts developed through workshops. The drama dealt with issues such as violence and sexual exploitation of girls by gangs and a later version on mental health was developed as a national resource for schools. The DPH described it as follows:

Y*oung people play the main character in the drama online. And all of the key decisions that happened, that that character has to make, you as a user, you decide what they do next. And then every single one of the outcomes are all filmed, so you basically write your own story. We did one on violence against girls and knife crime, gang crime. It was a very powerful drama.*

*Example: engaging young people in a Joint Strategic Needs Assessment for emotional health and wellbeing*

In one site, extensive and separate consultations had been carried out with parents of pre-school children, school-aged children and children aged 16-24, in order to develop an integrated assessment of children and young people’s emotional health and wellbeing. Engagement included working with Asian heritage young people who were trained as ‘engagement practitioners’. These young people then recruited and carried out interviews with 25 other young people from their community or social networks. Interviews were audio taped and transcribed, and this data was then included in the final analysis.

***Changing the provider landscape***

Changes in the provider landscape were highlighted as a potential impact of the reforms. The first national survey of DPH and CCG members of HWBs showed that over one third of respondents indicated an increased involvement of local authority employees (44%), volunteers (44%), VCSE organisations (39%) and pharmacists (36%) for preventive services. Responses to the second survey were similar with the exception of the VCSE sector where 60% indicated greater involvement in preventive services since the reforms. Innovation in case study sites was identified through changing contracts with existing providers, changing providers, involving the VCSE sector for specific services, involving the local authority workforce, pharmacies and dentists in health promotion and the encouragement of community-based projects.

Surveys and case study sites illustrated a spectrum of engagement with the VCSE sector both in the process of commissioning services and in their provision. It was argued that the VCSE sector could engage with groups reluctant to connect with statutory services, identify needs, raise awareness of health related issues, establish community-based activities for vulnerable or isolated groups and could work with people in their own communities, sometimes in partnership with services such as youth offending teams. For example, one survey respondent described active partnership and engagement across the VCSE sector, the local authority and the CCG reflected in a wide range of projects and another described close working with the Scrutiny Committee to identify needs of BMER communities. One CCG had developed a separate strategy for VCSE sector engagement and another respondent described a competition-based approach to developing community initiatives, through a VCSE consortium.

*Example: VCSE sector providing a 'Winter Warmth' advice line*

In one site, the contract for a ‘Winter Warmth’ advice line was transferred from an in-house local authority provider to a VCSE organisation. Whereas the in-house service was reliant on scripted responses to questions, the VCSE organisation was able to draw on the expertise and networks of over 300 volunteers, actively identifying need rather than simply responding to service requests, and taking action to address need immediately. Such action included referral to other services, but also practical action, such as arranging for a portable heater to be provided by another third sector organisation.

*Example: VCSE sector providing an integrated advice service*

In one site, a single advice service was commissioned from a consortium of three VCSE organisations. This was funded by public health with Children’s Services, Environment & Housing, Citizens and Communities and Adult Social Care, covering health trainers, drug and alcohol advice, and home adaptations.

*Example: providing a single referral route*

A survey respondent identified a 'multi-agency helplink' form providing a single route of referral for health and care workers to the range of preventive services that are provided through the Voluntary, Community and Faith (VCF) sector. The local authority and CCG had pooled their commissioning resources for VCF, commissioning through a consortium model to add value, promote joined up working and reduce duplication.

***Working with community networks and localities: developing community assets***

It was argued that pressures on the health and social care system from long-term conditions meant that communities had to become more involved, taking more responsibility for improving health and wellbeing. Often referred to as ‘asset transfer’, was the drive to stimulate community enterprises and provide public finance to community groups on the basis of their providing greater social value. This was often linked to public sector transformation.

Interviewees across most sites emphasised the importance of context, looking at the needs of communities in their localities, encouraging communities to help themselves, and finding ways of building community capacity, including volunteer involvement and local neighbourhood networks. One site was developing local knowledge, including annual ‘Healthtalk’ events linked in to the HWB communication strategy, with the aim of developing ‘locality stories’, identifying locality assets, and informing the Health and Wellbeing Strategy. Another site had developed ways of encouraging community groups or individuals to apply for funds to develop approaches to developing community assets rather than working through grants or commissioning the VCSE sector as in other sites.

*Example: community assets and public sector transformation*

One site focused on an asset-based approach to adult social care and locality planning. The site had adopted a strategy for transforming adult social care and health based on five strands: transforming the public’s health; accommodation and support; Care Act implementation; transforming through technology; and generating a sense of shared responsibility for achieving outcomes between the local authority and constituents. Key areas of progress which impact on post-reform public health services included an ongoing move from segregated services to better connection with local communities and use of mainstream services, use of technology to increase early intervention, and integrating services such as an integrated hospital discharge team. Linked to this was encouragement of an innovative and creative workforce.

*Example: mapping social networks*

One site used network approaches to identify social and economic need. This involved mapping social networks, assets and health profiles in a ward to understand how local social networks could stimulate new responses to addressing health problems, and new ways of growing local enterprises. A team of community researchers surveyed local residents and local residents were involved in interpreting and making use of the findings. A range of latent community resources was identified. This contributed to models for locality commissioning.

*Example: working through community champions*

Funded through the CCG and the local authority a survey respondent identified an early years’ programme in a deprived ward using community champions to target the 40 per cent of parents locally who did not use children's centres or other public provision. There were also physical activity champions. Other respondents highlighted the use of 'health buddies' identifying those at high risk of TB and of coaches, using person-centred approaches and concentrating on building skills to help people 'manage their own behaviours and make sustainable changes’.

*Example: community volunteer programme*

One site established a ‘whole authority’ programme to encourage and empower individuals, community groups and businesses to improve the social and physical environment. Examples include community volunteers carrying out litter picks and making improvements to areas of waste ground, and community groups holding inter-generational events with sponsorship and support from local businesses. The programme also has listening events for the council to hear about residents’ priorities and suggestions for improvement. In the annual report (2013-2014), the programme reported engaging and involving almost 20,000 volunteers.

*Example: training volunteers*

In one site, the Council for Voluntary Services (CVS) had developed a training programme offered free to all volunteers. The aim was to support volunteers and individuals who wished to learn new skills that would benefit both their own personal development and enable their voluntary or community group to develop. The training comprised six modules: good practice standards for volunteers, health and safety, equality and diversity, safeguarding and confidentiality, customer care and ‘Live Well’. The ‘Live Well’ module covered key health messages, plus awareness of signposting and referral options. Empowering volunteers in this way has opened up opportunities to engage with the volunteers themselves, but also the organisations they volunteer with, including groups who might not be engaged with health messages otherwise. A VCSE sector respondent highlighted trained volunteers who raised awareness of heart health and cancer prevention ‘using the language and methods that work best because they live in the same community and share the same social and cultural background’.

***Targeting services and addressing health inequalities***

As discussed in Research Report 5, there was a degree of consistency in the NHS over how health inequalities targets were to be met, premature mortality reduced and the health inequalities gap narrowed. Case study interviewees reflected a broader range of approaches. These included an emphasis on vulnerable children and the role of the local authority as ‘corporate parent’; a shift from universal to targeted approaches; an emphasis on ‘consultative’ rather than on ‘analytic’ approaches; a reframing towards priority groups; and cross-directorate approaches focused upstream. Public health investment was often directed to ‘early help’ initiatives. Targeting of services (including of traditional preventive services and support for pregnant women) was often highlighted and all sites highlighted the importance of local context and engaging with members to determine local priorities. Inequalities in access to services was often emphasised, especially for rural areas.

Interviewees often discussed health inequalities in the context of the needs of underserved and vulnerable groups, including migrants, socially isolated people, lone parent families and children leaving care. Projects highlighted by interviewees and survey respondents included listening events with BMER communities and identifying service needs for those affected by HIV, migrant communities, and travellers. Since the reforms, local Healthwatch had also become involved in identifying the needs of these groups, although not always working closely with public health teams in this area. In both DPH/CCG surveys, targeting towards areas of need was identified as requiring innovative solutions.

*Example: identifying inequalities in access to services*

In one site, local Healthwatch had worked with national and local VCSE sector groups, as well as residents, to undertake a project to help understand equalities in access to health services. Engagement activities were focused on five groups: BMER communities; people identifying as Lesbian, Gay, Bisexual and Transgender (LGBT); homeless people; people requiring mental health services; people with sensory impairments; and people experiencing rural and social isolation. Engagement methods were tailored as a result of preparatory work with group representatives. For example, a questionnaire for completion by homeless people was designed and distributed through an independent organisation with experience of engaging with this group. Other VCSE sector service providers assisted in the distribution and collection of the questionnaire, and a forum was also organised with an independent facilitator to engage with those who may not have wished to complete a questionnaire. As well as recommending action for improvement specific to each group, the final report also recommended cross-theme actions: (1) to adapt methods of communication to meet patient or community needs; (2) to have training for better awareness of specific disabilities, conditions and personal barriers; (3) to improve emotional and mental health support; and finally (4) to make better use of voluntary and community services to help people manage their conditions on a daily basis. In making these recommendations, the report concluded that statutory providers and commissioners should invest more in voluntary and community services, in order to help alleviate pressures and save money in the long term.

***Example: targeting an area of high need in relation to children with asthma***

Public health worked in partnership with other local authority departments, the CCG and a local radio station to gain information and improve understanding of the experiences of children and young people living with asthma in disadvantaged areas in order to improve outcomes. Initially, a 30 minute presentation was made to 4 schools, reaching approximately 600 pupils aged 5 – 19. Following this, a group of children and young people assisted in the production of an information/education pack. The local radio station and schools worked with a health professional to develop interactive podcasts, commercials and a poster competition which were all broadcast and advertised on local radio. Through travelling to the centres of housing estates with a ‘flashy bus’, information was made directly available to children.

***Commissioning for wellbeing***

**Many of the projects outlined above illustrate how different approaches were being integrated, so that unhealthy behaviours were not considered in isolation from each other or from the social conditions associated with them, and individuals were not considered in isolation from families and local communities.**

Closely linked to commissioning preventive services was a wide range of community-based projects which aligned with local government aims to increase community wellbeing. These ranged from general initiatives to promote healthy walks and use of green spaces, through family or community-based approaches, to specialised projects designed to promote skills and enjoyment whilst reducing social isolation. Councils could also encourage initiatives promoted by other organisations, such as 'Good Gym', where runners could build in social value through working on community projects or supporting older people en route by 'running with a purpose'.

In the survey of VCSE sector organisations involved in health promotion and prevention, no less than 62 preventive projects were highlighted (see Appendix 2 and Research Report 3) and the importance of recognising and addressing social isolation and mental health problems were highlighted. Projects included gardening for unemployed people, homeless people, and the most socially excluded or projects for those suffering from mental health problems or dementia. In one such project designed to offer a range of activities for homeless people as well as address problems of access to services, a VCSE sector respondent noted the benefits of their project on the mental wellbeing and employment prospects. An integrated and holistic approach was common to many projects, combining mental health and social wellbeing, while some (e.g., alcohol services) formed part of wider programmes. Advocacy was often combined with peer support and volunteering. Access to cancer screening services, for example, could be developed through training local people to act as volunteers, encouraging earlier take up of services. Activities (such as gardening, cooking or physical activity), as well as being therapeutic in their own right, could provide a way in to a wider range of services and support for vulnerable groups, including those with mental health problems. One project for homeless people offered ‘cookery, arts and crafts, gardening, walks and educational day trips’, addressing issues such as access to a wide range of services, poor housing, lifestyle choices and self-confidence.

These illustrate the emphasis on holistic approaches in the context of council responsibilities for promoting social wellbeing.

*Example: addressing social isolation in men*

The national survey of VCSE organisations highlighted a social enterprise delivering two projects to address social isolation amongst men. One project had the purpose of seeing whether the wellbeing of children might improve through improving the wellbeing of their fathers, using an asset-based approach which is based around ‘finding and sharing the wisdom of the community’. It was targeted at fathers who had limited contact with their children, or who lacked a support network. The project created a male-friendly space as well as offering father and child activities to enable bonding. The project helped a group of fathers who were social isolated to develop supportive bonds through ‘social narrative’. The survey respondent commented that ‘the early adopters have literally begun to transform their lives, overcoming long-term mental illness, volunteering, training and, in one case, getting a job after twelve years of unemployment’.

*Example: encouraging self-development*

A social enterprise delivered an eleven week course at a sports village, featuring communication skills, stress management techniques, assertiveness, relaxation and self-development. Although based in a sports village, the project emphasised that activities would not be competitive-sport orientated, whilst also tackling health issues such as anxiety, depression or poor-self-esteem in a non-clinical setting.

**4.3.3 In conclusion**

Case study sites and survey respondents provided many examples of innovation and this section has summarised initiatives selected to illustrate main themes highlighted by respondents. The research demonstrated that the parameters of what is included under the rubric of ‘public health commissioning’ are shifting.

First is the development of a public health-informed approach to commissioning across the range of statutory and non-statutory services commissioned or provided by the wider local authority and partners. Co-location of public health teams and the ability to make connections across public health and local authority functions, combined with an ethos of taking families, communities and local contexts into account, have all encouraged a movement away from single interventions. Conversely, the infusion of local authority expertise in procurement and in co-production has strengthened traditional public health services. Public health teams clearly have the potential to integrate public health and health promoting approaches into services for children and for other vulnerable groups.

Second, and related to this, is the involvement of public health teams in the wider integration agenda and in prevention, in the sense of managing demands on statutory services.

Third, is the involvement of public health teams in the activities of a wide range of directorates and other local authority functions (such as planning, licensing and leisure), which may lead to commissioning approaches which promote a healthy social and economic environment.

Whilst the research reflected these shifts in the focus of public health activities, there were mixed views over the changes. For example, some interviewees criticised the lifestyle focus of public health teams in the NHS and welcomed the increased focus on social determinants of health but others lamented a decline in traditional preventive services and weakened links with primary care since the reforms. This sub-section, therefore, also serves to illustrate changes in emphasis in public health commissioning, a change which may have implications for fulfilling the range of public health functions.

In practice, many innovative preventive initiatives reflect combinations of different elements, such as co-design, new providers and whole systems, holistic and collaborative approaches. Innovation, therefore, increasingly rests on combining approaches rather than focusing on single interventions. Whether such combinations can occur partly depends on the factors which support innovation, as described in section 4.2. This point is returned to in the discussion section.

Promoting local wellbeing – social, economic and environmental – is a key requirement for local authorities, reflected through decision-making across directorates. To this extent, local authority commissioning, including innovation in commissioning, merges with public health commissioning, although the extent to which health is explicitly recognised varies.

## How innovation is being encouraged, supported or incentivised

Whilst the range of examples summarised in sub-section 4.3 indicates local authority support for innovation in public health commissioning, the study also sought to identify through two national surveys if there were specific routes through which local authorities encouraged or incentivised innovation and whether there had been changes over time. National surveys of DPH and CCG members of HWBs (carried out in 2015 and 2016) asked respondents whether the local authority had created a climate for developing innovative approaches to public health across a range of different areas, such as prioritising areas where innovation was needed, providing time for rewarding innovation, facilitating cross-directorate working, using the public health budget to encourage innovation, and developing integrated public health services.

Table 12 compares results across nine questions. This demonstrates that there was a greater percentage of positive responses across all dimensions in 2016 than in 2015. Areas where there was most agreement over local authority support for innovation were in facilitating cross-council working with key partners (86%) and commissioning integrated services (also 86%) while the greatest improvement in support since 2015 was in the areas of testing new approaches, learning from failures, providing financial incentives for improving health through innovation and commissioning for integration.

Table 12: National survey results (2015 and 2016): the extent to which the local authority creates a climate for innovation

|  |  |  |
| --- | --- | --- |
| **Survey question: Has your local authority created a climate for developing innovative approaches to public health by doing any of the following**? | **% respondents agreeing**  **2015** | **% respondents agreeing**  **2016** |
| Prioritising areas where innovation is needed | 61 | 63 |
| Providing opportunities and time allocation for developing innovation | 45 | 49 |
| Facilitating cross-council working with key partners | 79 | **86** |
| Testing new approaches to public health services | 63 | 71 |
| Formally acknowledging efforts to develop innovative working | 50 | 54 |
| Learning from failures | 45 | 54 |
| Providing financial incentives for achieving improved health resulting from innovative ideas | 13 | 26 |
| Using the ring-fenced public health budget to encourage innovation | 50 | 57 |
| Commissioning for integrated services | 76 | **86** |

Respondents for the 2016 survey provided more responses (37) than respondents for the 2015 survey (24) for how their local authority had created a climate for developing innovation. Prioritising areas where innovation was needed was described as forming part of DPH reports or HWB strategies or as ‘under review’, with examples of innovation being prioritised, including adults with complex needs, deprived areas and workplace health**.** Providing space for developing innovation was being encouraged through awaydays, market engagement events (such as speed dating to develop new service models and partnerships) whilst there was also an example of an innovation award. Innovation through cross-council working with partners (including academic partners) was cited as being promoted through stakeholder events led by the HWB, multi-agency community wellbeing partnerships and via Sustainability and Transformation Plans. New approaches to public health services were being tested in relation to healthy lifestyle services, creating meaningful activity for people with mental illness, or integrating public health across local authority functions rather than through a separate public health service. Commissioning was described as a route for encouraging provider innovation through the nature of the contract, building in quality questions, for example, whilst a ‘prime provider’ model for services such as sexual abuse and drug use was also cited as testing out contractual innovation. There was also an example of using the public health grant for a social impact bond to tackle loneliness. Working through contracts was seen as a formal mechanism for promoting innovation.

Whilst the ring-fenced budget was described as funding core services, there was an example of the budget being used to encourage innovation through supporting a number of PhDs in priority topics, such as child obesity and adverse childhood experience. There were no examples from the surveys of learning from failures.

Interviewees in case study sites also raised detailed examples of how innovation had been promoted (summarised in sub-section 4.3).

Whilst section 4.3 highlights particular examples, the two national surveys provide a context for interpreting changes since the reforms on key issues such as new providers, approaches to preventive services, community engagement and co- commissioning and cross-directorate approaches. These are discussed in turn.

**4.4.1 New providers**

Table 13 summarises changes in providers of preventive services.

Table 13: National survey results (2015 and 2016): changes in providers of preventive services

|  |  |  |
| --- | --- | --- |
| **Survey question: Since the public health reforms are the following more or less involved in delivering preventive services in your local area?** | **% respondents ‘more’**  **2015** | **% respondents ‘more’**  **2016** |
| Volunteers | 44 | 42 |
| VCSE organisations | 39 | 58 |
| Health trainers and other peer support | 21 | 33 |
| Private providers | 21 | 28 |
| Local authority employees as part of local authority services | 44 | 47 |
| GP practices | 13 | 14 |
| Employee workplace schemes | 31 | 31 |
| Community groups | 28 | 47 |
| NHS Trusts | 5 | 17 |
| Pharmacists | 36 | 36 |

Whilst results were similar across both surveys for most provider categories, there were increases in 2016 in the percentage of respondents indicating ‘more’ for the following provider categories: VCSE organisations, community groups, health trainers and other peer support and NHS Trusts. However, with the exception of VCSE organisations, a majority saw little change.

**4.4.2 Approaches to preventive services**

Respondents were also asked about changes in approaches to preventive services, as outlined in Table 14.

Table 14: National survey results (2015 and 2016): changes in approaches to preventive services

|  |  |  |
| --- | --- | --- |
| **Survey question: Have the public health reforms encouraged any of the following approaches in your local area?** | **% respondents ‘yes’**  **2015** | **% respondents ‘yes’**  **2016** |
| Addressing clustering of unhealthy behaviours | 49 | 58 |
| Developing new integrated health and wellbeing services | 72 | 72 |
| Using community networks to identify underserved groups | 64 | 64 |
| Developing asset-based approaches | 72 | 69 |
| Using VCSE organisations to work with underserved groups | 64 | 56 |
| Using financial incentives for providers | 23 | 39 |
| Using local authority venues to deliver services | 59 | 61 |
| Using neighbourhood venues to deliver services | 59 | 69 |

Again, responses were similar with almost three quarters of respondents highlighting new integrated health and wellbeing services and asset-based approaches. However, there was an increase (from 49% to 58%) in respondents indicating encouragement for addressing clustering of unhealthy behaviours and in the use of financial incentives for providers (from 23% to 39%). In a subsequent question asking whether there was increased uptake in underserved groups in the areas listed above, there were increases in the percentage of respondents for all categories, with the exception of the first two categories, with a majority of respondents in 2016 highlighting community networks (from 29% to 50%), VCSE organisations (from 31% to 55%) and neighbourhood venues (from 19% to 60%).

**4.4.3 Community participation**

Increased community participation was a key element of the reforms and Table 15 shows a higher percentage of respondents answered ‘more’ for each category, indicating that the reforms have encouraged greater participation by communities in preventive services, an activity identified with encouraging innovation.

Table 15: National survey results (2015 and 2016): participation by communities

|  |  |  |
| --- | --- | --- |
| **Survey question: To what extent have the public health reforms affected participation by local communities in your local area in the following activities?** | **% respondents ‘more’**  **2015** | **% respondents ‘more’**  **2016** |
| Identifying local public health priorities | 23 | 39 |
| Identifying local solutions | 39 | 44 |
| Community capacity-building | 36 | 53 |
| Influencing commissioning priorities | 31 | 44 |
| Co-design of adult services | 33 | 42 |
| Co-design of young people’s services | 41 | 53 |

In relation to healthy lifestyle services, a higher percentage of respondents (72% in 2016 compared with 59% in 2015) considered that healthy lifestyles were being encouraged across directorates. For child obesity, in particular, there was an increase in respondents considering that initiatives to address child obesity were being encouraged across directorates (from 64% in 2015 to 72% in 2016). These results were reflected in specific questions related to initiatives for child obesity with increases in the percentage of respondents indicating funded initiatives in the following areas: using the planning system to regulate fast food outlets around schools (from 26% to 39%); active travel (from 33% to 53%) and promoting use of green space (from 44% to 67%). There were smaller increases in percentages of those considering that more lifestyle management services were being provided through the local authority (from 26% to 33%).

While results from both surveys have to be considered with caution given low response rates, the results suggest that in the key areas of community involvement, co-commissioning, cross-directorate approaches and identification of underserved groups there may have been changes in the direction anticipated by the public health reforms.

# 5. Strengths and limitations of the report

The strengths of this report derive from bringing together primary research on innovation from six different elements of the study: two national surveys of DPH and CCG members of HWBs (carried out one year apart); a national survey of local Healthwatch and VCSE sector members of HWBs; a further national survey of VCSE organisations involved in prevention and health promotion; interviews carried out with national stakeholders; and 90 interviews with a wide range stakeholders across ten case study sites. These sites reflected different levels of deprivation, a wide geographical spread and differences in political control. This has allowed for the analysis of a range of views across the statutory and voluntary sectors in different types of authorities and the compilation of numerous examples of what has been considered as innovative practice from different perspectives. The analysis covers the period from early 2015 (scoping interviews with national stakeholders) to September 2016 (completion of the second national survey of DPH and CCG members of HWBs).

While there are numerous case studies of how local authorities are fulfilling their public health responsibilities, this report explores the relevance of levers for innovation in the context of public health commissioning and develops a framework for public health commissioning to which the analysis of levers may be applied. This contributes to the neglected field of how innovation in public health is to be conceptualised. It also provides examples of what respondents/interviewees considered to be innovative in their local area.

There are, however, a number of limitations. First are limitations associated with each of the elements of the study, which are brought together for this report. While the case study sites and interviewee sample fulfilled selection criteria, our findings are limited by the number of sites – ten out of a possible 152 local authorities. This limits the extent to which we can generalise from our findings. All four national surveys had a low response rate, as detailed in Research Reports 3 and 4. There is, therefore, a risk that our findings are biased and where we report survey findings in this report, these should not be used as a basis for generalisation.

Second are limitations linked to the concept of innovation, which is interpreted in different ways, is sometimes criticised as a smokescreen for funding reductions and where the relevance to the public health field was sometimes questioned. We have adopted a contextual approach, reflecting what interviewees considered innovative in their respective local contexts or organisations and have not sought to impose a single definition of innovation as a yardstick against which examples are to be judged. In this sense, the report reflects ambiguities associated with the term.

Third, whilst we identified many examples of where the reforms had led to changes in commissioning and in how population health was being promoted, ethical requirements to preserve anonymity of sites and of interviewees work against detailed contextual information or the highlighting of good practice.

Fourth, not all the projects highlighted as examples may still be in place. However, this does not affect their relevance for an innovation framework.

Finally, as reflected in other research reports, the distinct contribution of the public health reforms to innovation can be difficult to assess, given financial and other pressures to transform the public sector which are ongoing and the existence of innovation which predated the reforms. It is also difficult to assess the impact of the public health reforms in isolation from the reduction in the public health budget (2015-16).

# 6. Discussion

Innovation and factors influencing the diffusion of innovative practice are subject to multiple and discipline-specific interpretations: this ambiguity enables these terms to be deployed for different purposes and in different ways. In the context of the health care sector, Baregheh, Rowley and Sambrook (2009) review three paradoxes of innovation. The first, summarised as the ‘uptake of the dubious and the rejection of the good’, reflects the risk of rapid diffusion of innovative approaches resulting from their ‘intuitive appeal’, rather than quality of outcomes. A second paradox derives from the fact that collaboration, participatory and network-based approaches are considered key for successful implementation but may not be enough to overcome obstacles arising from professional boundaries or individual interests. The third paradox relates to the fact that change results in new challenges and, in this sense, innovation also disrupts and ‘may diminish organisational and practitioner enthusiasm for quality improvement’.

These tensions were reflected in definitions of innovation offered by survey respondents and interviewees, as well as in views over what innovation meant in the context of public health. For example, in order to improve population health it was important to implement good practice across a wider population or ‘implement at scale’. For the voluntary sector, where funding was often contingent on being innovative, a focus on funding innovative projects could serve to displace effective practice, while commissioning strategies often failed to reflect innovative projects, such as those funded though Big Lottery, for example. Partnerships and networks (described as sideward or horizontal levers in this report) often needed sponsorship if they were to prove sustainable and there was variation in the extent to which case study sites promoted innovation in public health, as opposed to simply ‘rebadging’ existing local authority activities being funded through the public health budget.

Nevertheless, strong arguments were put forward for innovation in preventive services. Innovation was driven by the necessity of doing ‘more for less’ in a context of financial austerity, working across a local system to try and improve outcomes, while simultaneously reducing rising costs. Innovation was also required to address ‘complex and interrelated problems’, health-damaging social environments and the public health challenges which emerged from them. The interconnectedness of problems such as drug and alcohol misuse, looked after children and domestic abuse implied cross-directorate and multi-agency initiatives. For preventive services, effective solutions were likely to emerge through engagement with communities (of place, identity or interest) and service users, rather than through top-down modelling. However, while austerity was sometimes viewed as leading to innovation - making a virtue of necessity - it could also work against experimentation and risk-taking. It was difficult, for example, for members to approve expenditure where the outcome was not measurable within the current election cycle. The search for economies of scale through large block contracts could also work against the involvement of smaller VCSE organisations, notwithstanding their links with local communities.

Innovative approaches to preventive services in the new local authority context were facilitated by a the opportunity to recommission services as historical contracts came to an end, drawing on more rigorous procurement procedures and commissioning support available (with greater attention to service specifications. targeting ,value for money and outcomes) and often drawing on a wider range of providers. Recommissioned services often reflected a combination of increased community involvement or co-production, connections being forged across preventive and other local authority services, less emphasis on single interventions for unhealthy behaviours, greater recognition of the family and social context and the need to adapt good practice to local circumstances. There was also a greater emphasis on addressing social isolation and mental health issues, particularly in preventive projects highlighted by voluntary sector respondents.

Achieving greater effectiveness of preventive services through closer connections with communities and better understanding of local contexts and conditions was cited as one of the aims of the reforms, as public health teams could build on local authority experience in this area and on the local knowledge of elected members. For many survey respondents and interviewees, innovation in preventive services derived partly from increased community engagement and involvement and partly from better links with local communities through the activities of elected members. A comparison of national surveys, carried out in 2015 and 2016, indicates that there was greater uptake of preventive services by disadvantaged groups in 2016 than in 2016 and that in key areas of community involvement, co-commissioning and identification of underserved groups there were changes in the direction anticipated by the public health reforms. Also, interviewees argued that co-commissioning of services, especially involving young people, was more evident as services were being recommissioned, with examples related to mental health services, emotional health and wellbeing and sexual health. Closer links between public health teams and schools were also in evidence.

Prior to the reforms, integrated wellness services were already being encouraged (NHS Confederation, 2011; Winters et al., 2010), moving towards a holistic approach (encompassing physical, mental and social wellbeing) and away from a focus on single issues. Characteristics include being community rather than professionally led, an emphasis on building community capacity, promoting independence and improved quality of life, ease of access and the development of integrated referral pathways. The study showed that single interventions for unhealthy lifestyles were increasingly being recommissioned and replaced by integrated wellbeing services. While there was variation across sites in the level of integration, degree of investment and extent of alignment, some wellbeing services facilitated links with housing, welfare advice, health trainers and other local authority services. This meant that traditional preventive services were being recommissioned in ways more likely to recognise – and potentially able to address - social factors influencing health. New referral pathways were being created across preventive and other local authority services.

Services for drugs and alcohol and for mental health were also being recommissioned with a greater emphasis on co-commissioning, whole family approaches and peer support. There were also connections being made across services for drugs and alcohol and domestic abuse, allowing for a more integrated response.

The reforms were, therefore, encouraging new approaches to traditional preventive services through a more contextual and community-based approach. In some sites, the VCSE sector was also closely involved in the commissioning process.

In addition to these changes in traditional preventive services, there was also potential for innovation through public health perspectives being applied to traditional areas of concern of the local authority and through being included in contracts for services commissioned by the local authority, such as with housing associations. In some cases, public health teams had been made directly responsible for leisure services, managing the social fund or community engagement strategies, thus increasing the potential for public health teams to exert an influence. Co-location and/or dispersal of public health teams across directorates led to innovation, not just through influence but through ‘synergy’, that is, bringing together the different approaches of public health and local authority executives and members. This was cited as encouraging health needs assessment, targeting, marshalling of evidence, evaluation of new initiatives and improved outcomes, although some saw a risk of such integration leading to the dilution of public health skills. While health inequalities were often discussed in relation to the needs of vulnerable and priority groups, close working across public health teams and local councillors in some sites was also encouraging better understanding of heath inequalities within and between wards, promoting greater engagement of members with a public health agenda. There were also initiatives to embed public health activities into the wider local authority workforce (such as fire and rescue services identifying health and care support needs) in a way that may not have existed to the same extent prior to the reforms. There were, however, some reservations if such initiatives also led to reductions in public health teams. Public health training was being developed, reflecting the importance of a public health approach being incorporated across all local authority activities, as well as ensuring a sustainable public health workforce.

Innovation related to the reforms in directorates such as environment or planning was less evident than in ‘people’ directorates, although there were examples of new and systematic approaches to directorates improving health outcomes through developing service delivery agreements, implementing health impact assessments and adopting system-wide approaches to public health challenges such as child obesity. There were also indications that the attempts to increase health gain through investment in other directorates were, in part, a consequence of the public health grant being cut and also of its being used to support leisure and other services linked to community wellbeing.

The eleven elements of a framework for public health commissioning which emerged from interviewee accounts and survey responses can each be associated with innovative approaches. However, it is clear from the nature of public health challenges that a combination of these elements is often required, to include community engagement, actions across the wider system and the choice of providers reflecting a more holistic and contextual approach.

While interviewees highlighted many examples of innovation, whether innovation takes place at all is influenced by levers for innovation and whether they are aligned or in opposition. As described in section 2, innovation is influenced by a range of downward, sideward and upward levers. The most commonly cited downward levers included strong system leadership, leadership within the local authority in supporting innovation across local authority services and by local authority staff, and the need to respond to national austerity measures. Sideward levers for innovation were less commonly cited and often required leadership support, but partnerships across sectors could trigger a wide range of innovative practice: examples were raised in relation to the prison population, those at risk of offending; fostered children; and specific public health challenges such as promoting physical activity or addressing child obesity. Some members were more inclined to devolve decision-making, thereby facilitating sideward levers. Upward levers were the least mentioned, although there were examples of co-commissioning of services, research being carried out in conjunction with local communities of interest and of a community investment fund designed to engage communities in devising their own solutions.

A relative lack of upward levers for preventive services reflects the predominance of health care and arguably underlines the importance of elected members acting as advocates for public health, rather than this role being combined with other responsibilities, as was generally the case in our case study sites.

It has been argued that when levers for innovation are aligned, change is more likely to be implemented. In our study, there were clear examples of innovation reflecting such an alignment. For example, in one site, an emphasis on community assets and community-based initiatives in promoting population health and wellbeing was encouraged through downward levers (support of elected members in response to austerity, and in line with public sector transformation); sideward levers, as reflected in local partnerships and multi-agency approaches; and upward levers, acting on ward-based analysis and through funding for community-inspired projects, through open competition. There were also examples of local authorities using downward levers, including legislative powers in planning in order to control fast food outlets near schools and thus support action to reduce child obesity. In other cases, however, potential for innovation was reduced through a lack of commitment at elected member level in the context of other local authority priorities and statutory requirements, different views over the role of individual responsibility in relation to lifestyle or of the evidence base in the context of local implementation. Interviewees recognised the crucial role of member support as a lever for innovation and the role of public health teams in communicating with and influencing members. However, the leeway accorded to DsPH and their teams varied across sites.

The public health commissioning framework reflected in this report is not comprehensive but reflects examples raised by interviewees in the context of the aims of the study. It provides an opportunity to reflect on patterns of public health innovation and change by authority. In addition, the analysis of downward, sideward and upward levers for innovation can help identify enabling factors and the sustainability of individual projects for each element of the framework. At a strategic level, it can help identify barriers and opportunities for improvement. While it reflects a snapshot in time, the results of the second national survey, in 2016, indicate a greater emphasis on integration as a source of innovation. However, as indicated in Research Report 5, the extent to which prevention is promoted in new initiatives for integration is variable, with most attention focused on preventing the use of statutory services through promoting community-based support. It was argued that ‘business cases for risk share and gain share’, reflecting how prevention in one part of the system could impact on costs for another, would encourage a whole system approach that recognised the importance of prevention. However, the question remains over the extent to which the focus for innovation may change over time and whether the momentum for public health innovation is maintained as the changes instigated by the reforms become the norm.

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# Appendices

## Appendix 1: Examples of preventive services highlighted in case studies

## Appendix 2: Preventive projects highlighted by VCSE sector survey respondents

1. Food Dudes Healthy Eating Programme, for further details and evaluation see Lowe, F and Horne, P (2009). Food Dudes: Increasing children’s fruit and vegetable consumption. *Cases in Public Health Communication & Marketing.* 3:161-185. Available from: www.casesjournal.org/volume3 [↑](#footnote-ref-1)
2. **H**ealth **E**xercise **N**utrition for the **R**eally **Y**oung, HENRY was founded in 2006 – with grant funding from the Department of Health and the Department for Children, Schools and Families, <http://www.henry.org.uk/homepage/why-henry/the-henry-approach/> webpage accessed 5 August 2016 [↑](#footnote-ref-2)
3. During interviews, both local government and CCG interviewees showed how road traffic accidents and weather conditions which could be observed from their offices were being reported by partner services such as Police, Ambulance and Highways [↑](#footnote-ref-3)
4. Video telephony [↑](#footnote-ref-4)