The Third Sally Greengross Lecture

People, Place, Prevention, Power & Politics

How communities shape healthier, long lives

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Professor Kate Ardern, introduced by Sarah Neville (Global Health Editor, *Financial Times*) Chaired by Lawrence Churchill (Chair, ILC-UK) Hosted by the Local Government Association, 2 September 2026

Lawrence Churchill

Hi everybody, good afternoon. Welcome, all. While everyone gets seated, I'll tell you that I'm Lawrence Churchill. I chair the ILC, and I'll be up here for about two and a half minutes, I think, and no more than that. But it is my honour and pleasure to welcome you all to the third Greengross Lecture, and of course to make all of those important announcements for our safety and comfort. So will you please all join me in raising your iPhones and making sure they've switched to silent or switched off? Thank you. There is no fire drill scheduled for this afternoon, so if the fire alarm actually goes off we should assume it's there for real, and the best thing to do is to follow the ILC staff outside – we'll meet outside the building. And of course, I should make it clear that ILC is very grateful to, and thanks, the LGA for hosting us this afternoon.

Now, as most of you will know, the Greengross Lectures celebrate Sally's life and her unstinting endeavour to alert society to the certainty of ageing and the need for our social systems to adapt to the unfolding reality. Many of you will have attended the previous lectures, by Ashton Applewhite at the British Museum in June 2023, and by Professor David Halpern in the House of Lords in November 2024. It's lovely to see you here again this afternoon.

We all have our special memories of Sally, and in my case I met her in the year 2000, when she generously lent her support for work I was doing to promote the interests of disabled people. She was knowledgeable, involved, but most of all kind. But it was her critical insight that increasing longevity posed challenges for the young as well as the old that was, at that stage, unique. Her foresight that we should have to rebalance intergenerational equity and re-establish the social contract placed her up there among the intellectuals, but it was really her warmth and humanity that lingers most in my memory.

The ILC is honoured that Professor Kate Ardern has agreed to give the third Greengross Lecture, focusing on the role of communities in helping to shape healthier, longer lives. She will be introduced by Sarah Neville, the Global Health Editor of the *Financial Times*, whose eminent biography is set out in your programme. So it gives me great pleasure to welcome Sarah to formally introduce Kate. Thank you.

Sarah Neville

Thanks so much, Lawrence. I am delighted to have been asked to introduce Kate, having had the great pleasure of getting to know her over the past six years and discovering what a dynamic, imaginative and caring leader she is. In fact, I suspect we may have crossed paths many years before that, because, strange to relate, Kate and I attended the same school. Kate is four years younger than me, and as we all know, that kind of gap seems unbridgeable when you're at school and entirely irrelevant in adult life, of course. So I don't directly recall meeting her, but it does mean I have good insight into some of her formative influences.

Manchester High School for Girls, our shared alma mater, was and is dedicated to the notion of female empowerment. When it opened as the first academic girls' day school in the north of England a little over 150 years ago, its founding articles very explicitly set out a mission of gender parity – Kate and I, I think, could both virtually recite it by heart. It was to provide for Manchester's daughters what has been provided without stint for Manchester's sons. It was an environment in which it would never have occurred to any of us, or to our teachers, that we couldn't achieve any career ambition we put our minds to – very far from a universal attitude among girls or teachers in the 1970s. It helped that the school's history was directly intertwined with that of the suffragette movement, Emmeline Pankhurst having chosen to educate her three daughters, Christabel, Sylvia and Adela, there at the school – a heritage of which Kate and I, and all of our fellow pupils, were very aware as we were growing up.

So while at school, Kate was not only imbibing this doctrine of gender equality, but also pursuing one of her enduring passions, music, in which she'd been steeped from an early age. Her mother was a professional musician – pianist and composer.

(To Kate) Pianist and composer, sorry. But you can sing, as we're about to find out. And of course, Manchester itself has a rich musical tradition, not least on account of the Hallé Orchestra, and Kate is to this day the youngest person ever to sing in the distinguished Hallé Choir, having been allowed to join at just seventeen on the strength of her impressive audition. Not long after, she set another record when she performed with the choir at the Last Night of the Proms, where again she was the youngest person to appear on the stage that night. So you're getting the picture: Kate is multi-talented, and she was an outperformer from a young age. Her belief in the solace to be found in music is something Baroness Greengross would have recognised and supported. Under Sally's leadership, the ILC set up a commission in 2018 exploring the importance of music-based interventions in prevention, care and

quality of life for people living with dementia, and more recently the Council has carried out work on the nighttime economy and the impact of cultural and social activities, including live music, on healthy ageing.

Kate's love of music led her, very unusually for someone who had determined on a medical career, to do arts A-levels instead of studying the sciences. After careful research, she had concluded that much of the A-level science curriculum wasn't that applicable to medicine in any case, and that as a discipline it was as much art as science. She'd been set on becoming a doctor since the age of five, when she contracted measles in what turned out to be the last big outbreak before the introduction of the first vaccine a year later. She experienced life-threatening complications, some of the sequelae of which are still with her today, she tells me. Her life was saved by the NHS, and most especially by the care and skill of her family's GP, Sydney Lester – *(to Kate)* I like the way you still remember his name – who had in fact delivered her. Shortly after her birth, his swift actions had also saved her mother's life when she experienced a serious postpartum haemorrhage. Kate had her first blue-light ambulance ride at just four hours old.

Professor Kate Ardern

Destiny.

Sarah Neville

Indeed. Well, all of that might have put some people off doctors and hospitals for life, but in her case it gave her her vocation, and she went on to be accepted at the University of Manchester Medical School. I'm indebted to an interview Kate did with the Nuffield Trust shortly before the start of Covid, back in 2020, for an insight into her decision to enter the field of public health. She explained that when she was a junior doctor back in 1988: *"At 8am one day, I saw my tenth heart attack victim of the day. He was thirty-eight, with two young children. What struck me was not that I had saved his life, but that he shouldn't have been there in the first place. It was a failure of prevention. I thought we as a society should be doing better than this. I should be doing better than this. It's what made me think of public health as my future."*

Kate began her first role in that field in 1990, working for a succession of different health authorities, all in the northwest. It was during this time that she began to develop the ideas that have underpinned her practice ever since, particularly her belief that physical and social geography are critical to how individuals and communities function, in terms of resources, infrastructure and behaviour – and she attributes this way of thinking, in part, to being the granddaughter of a geographer, which I thought was rather nice to hear.

She moved to become Director of Public Health for Wigan in 2008, in what was initially a joint appointment with Wigan Council – a silo-busting approach, which was one of the things that appealed to her about the role. And in 2011 she was finally able to put her principles fully into action through the pioneering Wigan Deal. In a very positive assessment of the Deal in 2019, the King's Fund described it as

"empowering communities through a citizen-led approach to public health and creating a culture which permits staff to redesign how they work in response to the needs of individuals and communities." At the heart of this, the Fund said, was an attempt to strike a new relationship between public services and local people.

The importance of bespoke local approaches came to the fore during the pandemic, and that was when I really got to know Kate as a local leader battling for the interests of her community. I remember the conversations you and I had, Kate, during those months, because you weren't getting the data you needed about individual patients with Covid in your area, and that was hampering your ability to identify and control local outbreaks – just one of the issues you were facing, but an important one. It took you four months to get that data, I remember, after Andy Burnham, among others, took up the cause on your behalf. At the end of that unbelievably testing year, the *FT* named Kate one of its Women of the Year for her role in fighting the outbreak, and when I interviewed her for the special edition of the *FT Magazine* we ran to celebrate those women, she told me the pandemic had laid bare a lot of things – structural inequalities in society, the north-south divide – but had also exposed something we always knew but perhaps hadn't fully recognised: a tension between centralisation and devolution. That polarity has now become the terrain on which all of politics is playing out. The leader who supported and helped you get the information you needed in Manchester, Kate, is now Prime Minister. It's the perfect time to hear from you about the value of place and how it can change lives. Over to you, Kate. Thank you.

Professor Kate Ardern

I've now got to follow that introduction, ladies and gentlemen. Thank you, Sarah. I was hugely honoured to be named one of the *FT* Women of the Year 2020, because on the list with me were some very notable and exceptional women – Ursula von der Leyen, Gretchen Whitmer, Sarah Gilbert and, much to my utter delight, Miuccia Prada. I never thought I'd be on a list with Prada.

I've entitled this lecture "People, Place, Prevention, Politics, Power," because that's very much at the heart of what placing communities is about. I'm going to talk about three examples – not just Wigan, but obviously Wigan will feature – and there are eight lecture themes running through this. On the right-hand side of the slide I've got humanity, hope and health, so hopefully you'll hear me repeat those words throughout the lecture.

What I'd say to you about place, to start off with, is that we've been a very centralised nation in England in particular – obviously Wales, Scotland and Northern Ireland are in a different situation, but England is very centralised, and it's been very paternalistic as well. One of the lessons from Wigan was that both the politicians and the professionals, as well as the public, went on quite a journey from paternalism to people power. It's an interesting journey to go on together, because it does mean power-sharing, and that's quite a challenge for organisations, individuals and professions that are used to having power. Power is not always given up

willingly, as we know from our great ancestors – Sarah, from Manchester, who fought for our right to vote, not just the Pankhursts, but I'm thinking of just over 200 years ago, Peterloo: the ordinary weavers of Lancashire and Manchester. Women were part of that, by the way, at Peterloo; they were part of that demand for universal suffrage that was put down that day. But the journalists of the day, the forerunners of what was then the Manchester Guardian, were there to record those events – so there was really powerful investigative journalism linked to people power.

I'm indebted to the Health Foundation for this particular slide, one I've used before. It was about that enabler of trying to change from, or evolve from, the welfare state of the 1950s – which was very pertinent and needed in the immediate post-war situation – to an enabling state, where we don't disable people by disempowering them. I'm indebted to my former leader, the late, great Lord Smith of Leigh. Peter Smith was a fantastic council leader, a very enlightened one, and he went on a personal journey about the need to empower and invest, and to provide hope and confidence in local citizens. He truly believed in public health, and I will be forever in his debt for his investment and his belief in me. He always said the reason he believed in me was because when I said I was going to do something, I got it done. So a bit of a tip there, if you want to impress a senior politician.

But I'm going to go back before my Wigan days, to earlier in my career. One of the things I got involved with during the mid-1990s was the development of health impact assessment, because the importance of place was really central to my thinking about public health, as Sarah has outlined. I was working in Stockport at the time, and the thing that struck me – and it may sound like a bit of a eureka moment – was that planners are very important for public health. Planners are key to place, because planners decide where things go; the whole planning legislation framework is absolutely critical. So I got involved in developing health impact assessment. At the time, it was only done after an event – say, like the Braer oil disaster – and I thought, why are we doing it after an event, why aren't we actually assessing the health impact of planning decisions before they're enacted? That was how health impact assessment came into play, and I worked with Alex Scott-Samuel, Martin Birley and Mike Eastwood at Liverpool University to devise the Merseyside Guidelines for Health Impact Assessment.

Hands up – anyone here ever used Manchester Airport? All right, a few. Have you ever used the integrated transport hub that has buses, trains and trams? Someone's nodding – it probably should be named after me, because that was one of the recommendations we put into our health impact assessment, which was the very first one to be done prospectively in the UK, for Manchester Airport's second runway. So whenever I go through Manchester Airport, and through that transport interchange, I always think, that was one of my recommendations – there's something, putting it actually into action.

We went on to do a significant number of health impact assessments during the 1990s, and the one I'll briefly talk about, because I think it's very relevant to

discussions going on today around housing and health, and the whole agenda of building new homes for people, was the one we did of Liverpool's strategic housing policy, at the end of 1999. That was what we set out to do with it – a whole-community, whole-societal approach to looking at housing. We came up with a number of recommendations, some of which I think MHCLG, Angela Rayner and Matthew Pennycook might want to look at, because they're just as relevant today as they were when we came up with them in 2003. Note the recommendation on community consultation, and on investing in that and addressing things like low literacy and numeracy within a consultation process.

But the one I want to briefly talk about is the participation of children and young people. I have to say that politicians at the time were not very keen on the idea of talking to children – what do they know about housing? I argued fiercely for this, saying: what's the first thing a child draws that isn't a human being or an animal? It's your standard play-school house. It's where they should feel safe. Too many children, unfortunately, do not feel safe in their homes, but home is important – it's absolutely critical to a child's development. So I argued fiercely for this, and we brought in Save the Children, because I'm not an expert in children's research – but one of the things health impact assessment teaches you is what you don't know, and to find the people who do know what you don't. So we talked to Save the Children and got them involved, and we got detached youth workers involved too. To their credit, two head teachers in primary schools in Anfield dedicated a whole day for their Year Six pupils to participate in a "planning for real" exercise. We got fantastic insight and information from those children – their hopes, their dreams, their fears about the community they lived in, what they wanted to see happen with housing, what a safe environment for children to grow up in looked like – just as insightful as any adults. The cabinet member I was working with, who had been sceptical, looked at the insights that came through and said, "you were right – children are very observant about what goes on around them in their communities." From now on, they would be part of every consultation, and that has happened to this day – Liverpool includes children and young people in its strategic consultations.

I was particularly moved by one eight-year-old who said, in his response to us: "Thank you. I've really enjoyed taking part in this. I've really enjoyed being able to give you my ideas about what should happen in our community. Thank you for listening, and thank you for taking me seriously." Isn't that important – adults taking children seriously? Our detached youth workers came up with something similar. We had a couple of young people who came to the launch of the HIA report, and they were very keen to meet me, because, as their detached youth worker said, they knew I was the person who had fought for them to be involved. These two young women from Anfield came up to me, very excited, because, they said, participating in the health impact assessment had given them the confidence to apply and be accepted onto Operation Raleigh. As one of them said to me, "I never thought Operation Raleigh was for the likes of me – I'm from Anfield." You see, place does matter, doesn't it? Because some places get stigmatised, and the people

within them get stigmatised too. She had developed the confidence to see beyond that, and to know she was just as worthy of a place on Operation Raleigh as somebody from – I'll use the posh bit of Liverpool – Woolton. So it's important, I think, to recognise that place can be negative as well as positive, but the people within a place sometimes need their confidence boosting, and people believing in them – and that's what we saw with those two young women.

I'll now come on to the Wigan Deal, my second example, because it was quite unique in many ways. I think it was a response to austerity and the fact that we had to cut council budgets, but we did that in a very different way: we invested upstream, in prevention, and we invested in local communities. That was partly the political journey I mentioned, that Peter and his cabinet were going on, but also the professionals – the managers in the council – needed to be alongside this too. We needed to think differently and do things differently: not just about co-location of teams, not just about partnering in a true partnership sense – that is, as equals with the VCSE sector and community groups – but actually thinking about how we behaved.

The key to success here was working with an anthropologist. I've always said the NHS needs a chief anthropologist to teach it how to talk to people, because we come into conversations with a power difference, with a professional assumption, when we're talking to the community – and you need to ditch that. So we worked with Robin Farrow, and developed something called DEAL training – induction in place, not just induction in an organisation, but induction in the way the place operated: its history, its geography, its social connections, its culture. Very important to getting the context and narrative of place right. That meant we embedded it within all of our HR processes – recruitment, staff development, manager development – so everyone had to go through DEAL training. That ethnography-type training was really important in helping us ditch assumptions about both the place and the community we were proud to serve.

Interestingly, the folks who found it most challenging – because part of the training sent you out into Wigan to have a DEAL-based conversation with a random stranger – you know what I'm going to say next, don't you – were some of our NHS colleagues, who said, "we can't go out and have a conversation with a random stranger," and I'd say, "but you do that all the time." The difference is, they come into your environment, your space, where you're in control, and they're coming to consult you. You're being asked to go out and just sit down and have a human-to-human conversation – no lanyard, no badge, no uniform. The power is equal and shared. And it was great – I remember doing it myself in the Grand Arcade cafe, and I came back with a mine of information, particularly about buses. Buses are very important in Greater Manchester, as you may have gathered, and they were especially important in Wigan, because Wigan isn't connected to the Greater Manchester tram network, Metrolink. So that idea of being flexible, of meeting people where they are, of going on that journey of partnership, was critical to the Wigan Deal.

The other narratives, or principles, that we came up with – because it's not a model or a one-size-fits-all approach, that's always been the problem with centralisation in England, we're always looking for quick fixes, for a one-size-fits-all model, and what Wigan demonstrated was that doesn't work – you've got to build the narrative with communities upwards, not impose a top-down model. So we came up with some principles: investing in people, working with your workforce so that culture change starts with us, having a different sort of relationship with communities. One of the things we did was buy an IKEA sofa and go around the borough having "dropping in" conversations, and we got a mine of information and views back about what the priorities should be. Interestingly, public health came up as quite a big priority with our citizens – who knew? You wouldn't always hear that from professionals, but you'd hear it from our citizens. It's also about enabling people – there's a use for things like AI and digital, but it's about enabling human interactions, not human interactions being subservient to the needs of AI and digital. In other words, I think we've got some of our conversations around the digital and AI agenda the wrong way round: technology is a servant of humans, not the other way round.

It was also about thinking about how we commission things differently – looking at transformational rather than transactional commissioning. In other words, look at outcomes, look at the value we add to society, rather than just activity, which tends to be at the heart of most commissioning. Understanding that it's a belief and a movement – in other words, that it creates a movement for change. I'm indebted to the Robert Wood Johnson Foundation for this particular slide, because I think as a country England is very stuck in the past, in a deficit model of thinking, particularly about people – that people are a problem, that people can't be trusted to make their own choices, that we've got to do it for them. If devolution is going to work, if we're going to move forward, we've got to get into the mindset of an asset-based, strength-based approach. That was a big lesson from Wigan: a strength-based approach is important, because people have solutions, they're not the problem. That's going to be a challenge for organisations, professions and individuals, to stop thinking in that old way and start thinking in a new way – and I watch with interest the battle our new Prime Minister is going to have with, perhaps, some folks in Whitehall about how that happens. That's what he needs to win.

Why does geography matter? Well, I alluded to history and geography being important to the understanding of place, and it is. When we were having this debate in Wigan around primary care networks, the standard thing was, "Joe Bloggs wants to work with his mate down the road because they get on" – not thinking about how GPs are actually very integral to that sense of neighbourhood and place. The now-former council leader, David Molyneux, who was deputy leader at the time, when we were having this debate, marched us into Wigan Town Hall council chamber and pointed at the ceiling, where fourteen proud banners hang – the fourteen township banners. Yes, we have fourteen flags in Wigan, not just the borough flag – and he said, "that's the geography the community recognises." Some of those townships appeared in the Domesday Book – long before the NHS or councils, by the way. Sorry – councils did exist; shire councils were in place from, I think, 963. Local

government long predates the NHS. But Dave's point was that we needed to work with the geography communities recognise as their sense of place, as opposed to our sense of place. That was really important, and the primary care networks developed around the geographies of the twin townships – which, helpfully, had populations of thirty to fifty thousand. Fortuitous, wasn't it? But you can see how you might do something similar in other communities.

That enabled us to build anchor institutions around neighbourhoods. Anchor institutions are often thought of as hospitals, but we built our community neighbourhood anchors around the two places that have registered populations: schools and GPs. Now, if we go down some of the reforms I know are being thought about – why don't dentists or community pharmacists have a registered population, and get anchored into that sense of neighbourhood too? Isn't that where neighbourhood health should be going? We also used recognised local community physical assets, like libraries, as our neighbourhood health hubs – no need to build new ones, use the assets communities already recognise. Very important, and I'll come on to why in a minute.

We invested in people and in strengthening our community assets – and I'm very glad William's here from the Royal Society for Public Health, because we made extensive use of the Royal Society for Public Health's Community Health Champions programme and its Level 2 health improvement qualification, which we worked on with our VCSE sector across the community. That was a really empowering piece of work – we ended up with over 23,000 community health champions of one sort or another, hooking people in through different routes: dementia friends, mental health friends, CVD friends, cancer champions, whatever it might be. Investing in the community was incredibly important, investing and believing in people's ideas, and linking that to a DEAL Community Investment Fund based on public health principles and actually delivering public health outcomes – but I didn't tell them what to do. That was the important thing.

Some of the comments that came back from the community – the one I'll pick out, because I think it's very important, is one about a group of young mums: disengaged from school, poor literacy, no qualifications. And here's the telling phrase about believing in people: an absence of praise. They'd always been told they were failures, that they weren't any good. If you're always told that, you start to believe it, and it takes a lot of investment and encouragement to change that mindset. But what Community Health Champions did was help us change that mindset, help people get to a sense of "I can do these things, I have got skills, I have got knowledge, I have got ideas, I have got hopes, I have got dreams." Our job, if you've got some power and some knowledge, is to help people realise that true meaning of education, isn't it?

We also invested in place – in the natural green space at places like Pennington, which this week has just seen its first glossy ibis, very exotic; in places like The Galleries and Leigh Sports Village, which has a huge community hub around it; and in Haigh Hall, a stately home donated to the council, with a wonderful park attached

that comes right down into Wigan town centre. That investment, and the pride and love people have for these places, was something we had to invest in and support.

It also led me to do something very different with the public health annual report. I was thinking about how I might change what an annual report looked like, because when they were first developed by the old medical officers of health, we didn't have live statistics – we didn't have things like Fingertips, or Inform, or indeed the Better Health Index from ILC's own work on indicators. We didn't have that real-time data, so what we tended to produce were big, thick, statistical reports. Great for nerds, but not great for the public – it doesn't tell the story of place. So what I moved to doing – and this is the frustrated Steven Spielberg in me – was to produce community public health movies. I worked with Martin Green from Wigan Little Theatre, and his cameraman Ian, who was BBC-trained. We'd spend nine months on it: I'd give them the theme for the year, have a member of my team working with them, and send them out to interview people right across the borough, all ages, to get their views on that theme. I had no idea what they'd come back with – it could have been awful, it could have been a real challenge, and some of it was. But that's important, because I needed to be challenged on some of my views too. I might have had set views on homelessness, or on the role of arts in health, but people with more knowledge and experience, and better ideas, needed their voices heard as well.

So what came back was a documentary-style set of videos, split into chapters for people to digest easily, and it became the Wigan Public Health annual movie – not Kate Ardern's public health report. Very important. What I was doing was putting my trust in the community to come back with great ideas, which they did, and ceding a bit of my power so they could have their voice heard. I think that was also important in showcasing what Wigan people really had to say, challenging some of the stereotypes they'd had to put up with. I'm hoping this will play – you won't hear all of it, just a little bit. This was from my very last movie, called *A Sense of Belonging*, about the role of arts and health. I'll give you a slight flavour.

Speaker 4 *(video clip)*

Theatre, performance, spoken word and creative writing allow people to have a voice and improve self-confidence. From schools to community organisations, the art of storytelling is happening dynamically all over the borough. We got the opportunity to train with some of the Royal Shakespeare Company staff who worked on the production of *Matilda*. The children all got the opportunity to go and watch *Matilda* being performed on the stage, which was amazing, because some of our children had never experienced anything like this before – it was an amazing opportunity for them. The training we received also helped us with our own confidence – nervous, adrenaline rushing through, and I just loved it.

Children who are looked after are from families that have been split up, and their children have been removed, mainly due to safeguarding issues, and they are now in the care of the local authority, with foster parents, or in some cases with adoptive long-term parents. We wanted to help support these children with activities they

could do for their wellbeing, and to give them opportunities to develop their skill set too, in an environment supportive of their needs.

Professor Kate Ardern

So just a short flavour – the slides will be available afterwards, if you want to have a look, and that report is on YouTube as well. Just a sense there, from Nikki, about looked-after children; you've heard about the role of theatre, and about how it made Blaine feel. Fantastic – that brings public health to life, doesn't it, instead of it being a dry subject.

Of course, we were very indebted to the King's Fund's Sarahs here today for doing the independent report on the Wigan Deal, and my favourite comment, from Dan and Chris, was that whatever else we had or hadn't achieved with the Wigan Deal, we'd given our staff their vocation back. That's a really important thing to establish – so thanks to the King's Fund for doing that.

My final example is how we then used the learning from the Wigan Deal when we faced an enormous, unknown challenge in the Greater Manchester Covid response and our local borough response. It was about pivoting that asset-based approach from health and social care integration and health improvement into health protection. One of the challenges for my own profession is that we've divorced health protection from the rest of public health – divorced it from place. I'm not arguing health protection doesn't need some very expert scientific assets and developments, but health protection is rooted in communities. That's how public health began in the 1850s, with William Henry Duncan and Liverpool's public health pioneers – they were dealing with cholera epidemics, a health protection matter, and yet we've allowed it to move out of the community. It needs to go back. That may come up in the Q&A, but it's something we found in Greater Manchester: that whole-societal, whole-system approach was absolutely critical to getting a coordinated response to Covid.

That was set out in how we pivoted our DEAL model, and those community hubs I mentioned earlier across the twin townships, into providing humanitarian assistance. We thought it through as a different geography – what was needed at a neighbourhood level, right through to borough-wide infrastructure. This is a helpful way of visualising what I mean: thinking about geographies of scale, and perhaps a useful lesson for devolution – it's not all one thing, done at Whitehall level, or all done at borough level; there are different geographies of scale even within boroughs. We saw that as a way of aligning particular services: things that should only be done at a neighbourhood level, and things that need to be done at a borough-wide level. A much more sophisticated look at geography, rather than a one-size-fits-all, all-or-nothing, national-or-local approach – that needs to be part of the thinking around devolution. Perhaps someone might like to take that back to the Department of Health and Social Care as a model for neighbourhood health, you never know.

Why is that important? Because pandemics are with us – they will happen quite frequently, Covid was my third – and they begin and end in communities. I can recommend a wonderful documentary, commissioned by Debbie Abrahams, MP for Oldham East and Saddleworth, that looked at the experience of three families who lost relatives to Covid. She had five experts – Michael Marmot, Clare Bambra, Hafid Naqui, Rachel Clarke and myself – giving insights on what should happen in planning for the next pandemic. I know we want to forget about Covid, but we can't – it's absolutely crucial we learn the lessons from that experience, because the sequelae are still with us.

There's some further reading I'd recommend: the historic and geographic patterns of health inequalities, a report by the British Academy and the Academy of Medical Sciences, which looks specifically at things like intelligence and lays bare structural inequalities; Michael Marmot's report with the Health Foundation, *Build Back Fairer*, and his specific report for Greater Manchester; and the experiences of directors of public health through Covid – I was one of those interviewed for that report.

What have I learned through those three examples, and through my experiences in public health? I think there are some valuable lessons for the ongoing discussions and debate around devolution and the role of communities and place. We need to really put in place Michael Marmot's recommendations – we haven't done that, we should. We need to stop seeing community wealth-building and community health-building as competing: health and wealth are absolutely intertwined, you can't have one without the other. We need to think about investing in place in a different way – the work I was involved in with the Impact Investing Institute, looking at the role of pension funds investing in communities, is really important. We need to think about investing locally; that was, if you like, a version of the Wigan Deal Community Investment Fund, and GM Livewell – Greater Manchester Livewell – is an upscaled version of that approach, investing in the power of communities and the role of the VCSE sector to provide wellbeing.

Finally, I'll come on to some work I've been involved with, with a number of colleagues including colleagues from the King's Fund and others, with Lord Filkin – very appropriate in this building, as he's a former chief executive of the LGA. Geoff is passionate about the role of prevention, and investing in it. We came up with a series of reports, under the badge "A Covenant for Health," on the King's Fund website, which were really a prescription for government around the role of prevention. In that, local leadership is crucial – you devolve by design and default. That's interesting, because it's come up recently in discussions around devolution, where colleagues across Whitehall are being asked to make the case for retaining things nationally, otherwise you devolve it. So we think devolution is important, and getting it right will be very important. Local authority finances are very crucial here – Paul will be pleased to hear me say that. But putting the health back into health services was taken out in 2015, and we need to look at the financial flows to invest in and incentivise prevention, which the Institute for Government has recommended.

Why invest in people, place and prevention? Well, I'll summarise what Geoff says by saying it's a vote-winner, Prime Minister – I might message him later. But yes, the public do want more action on improving society's health, not just the NHS, but seeing people live healthier, better lives, and that has never been more urgent.

So in conclusion: it's about a coalition of the willing, working with people you perhaps don't normally work with; a really strong narrative of place; recognising that public health isn't just about a group of experts, it's a whole-societal, whole-system approach; learning to be an expert on tap rather than on top – in other words, a servant of the people – and investing in communities' ideas. We need a model of public health that's about citizen-led public health, not just experts in public health. Experts are important, but they are servants of the people.

I'll finish with this wonderful quote from Sally, because I think it sums up why people want to be healthy. It's not to sort out trolley waits in A&E, or corridor care, as important and as headline-making as those are – it's because we want to live life to the full, with the people we love most. In other words: humanity, health and hope. Thank you for listening.

Sarah Neville

Thanks so much, Kate – that was wonderful. In a second I'll throw it open to the audience for questions, but I want to pick up on what you said towards the end, about Whitehall officials being asked to explain why something shouldn't be devolved. Are there aspects of the NHS that can't, or shouldn't, be devolved, in your view?

Professor Kate Ardern

I think, again, it's economies of scale. If you're thinking about negotiations with big pharma on drug pricing, that's clearly a national scale; the work of the Medicines and Healthcare products Regulatory Agency is clearly a national priority. Setting standards is important too – setting out what success looks like should be done nationally. I also think there are elements of the organisation of specialist health services: highly specialised, high-cost, low-volume services – some clinical genetics work, for example – are best done at a national level. You'd still have national networks for things like burns centres, plastics, paediatric intensive care, neonatal intensive care. So there are things that clearly lend themselves to national oversight or ownership.

But a lot of other things can, and should, be devolved. I always get the argument about postcode lotteries – we've already got a postcode lottery, in terms of access, outcomes, inequalities and performance. Look at the maternity scandal – centralisation doesn't always produce good quality, good access. Julian Tudor Hart's inverse care law is still alive and well, decades after he came up with it. The Black Report recommendations of 1979 – yes, I'm old enough to remember those – still haven't really been delivered. We still have the challenge of people getting appointments in brown envelopes they can't read, appointments at nine o'clock in

the morning; we now have the added problem of digital exclusion and digital inequalities too. Jess Morley, who spoke at a Nuffield Foundation health policy summit a couple of years ago, got into that really well, I thought. We've got to fix the basics.

One thing that might come as a surprise: workforce planning should be devolved, and linked to things like the post-16 education agenda that mayors now have. Those relationships with universities and FE colleges could be much better managed at a strategic or combined authority level, and linked to things like graduate apprenticeships, modern apprenticeships – new pathways into the workforce. That would be a challenge, but I haven't seen the workforce fixed nationally yet. Time to try something different.

Sarah Neville

Fantastic. Well, I'm going to throw it out to all of you – we've got some roving mics. Would anyone like to kick off with a question? Yes, the gentleman there.

Ian Cassidy

Hi there, my name's Ian Cassidy – Chief Executive of the national body that supports the U3A movement. I wanted to ask two separate but related things, if that's all right. First, you mentioned prevention as a key aspect, and working with community organisations. Speaking as someone who used to lead a VCSE group involved with integrated care boards, I found our language around prevention was totally different: the VCSE sector wanted to talk about prevention as preventing ill health from happening, whereas public health and the NHS wanted to talk about prevention as preventing ill health from getting worse. I was interested in your view on that, and how you bridge that gap – obviously both are upstream, but one's a bit further upstream than the other.

My second point was about the ceding of power within communities. In past roles, I've led organisations looking for money from local authorities, where that ceding of power was linked to the money – "all right, well, let us spend it." But I now find myself leading an organisation that doesn't need money – always happy to take it, to be clear – that has a movement of 435,000 older people out there keeping themselves fit and well, but there's no real mechanism to engage with a local authority, because we don't need anything, and they don't quite know what to do with us either. So there's a movement there that could be engaged, but how do you work with people who don't want money?

Professor Kate Ardern

That's a fascinating question. On your first point, I'd be very disappointed if your experience of public health professionals wasn't of people interested in preventing ill health in the first place, because that's the foundation stone of public health.

Ian Cassidy

A commissioner once told me it wasn't their job to pay for yoga. That was the perfect example for me.

Professor Kate Ardern

I think that's because, in some instances, public health has been reduced to a set of commissioning services, as opposed to public health being what a council does – at the heart of all of its activity. Councillor Molyneux, who I referenced earlier, said we will have failed with the public health transition if all we do with public health is think about how the public health grant is spent. "Your job, Kate," he said, "is to tell me, or advise me, how the whole of the council's endeavour, and every person in it, contributes to health improvement." I think it's that mindset change that needs to happen – thinking about public health in a much broader sense, not just as a set of services, or a biomedical model that thinks it's great because we've got smoking cessation built into an elective care pathway. That should be in an elective care pathway anyway – it doesn't need a public health professional to tell people to do that. So it's about shifting that mindset, and I guess it's the job of the faculty, of the Association of Directors of Public Health, and the great work Paul and the LGA do bringing amazing examples to life, around good public health practice – that whole-place, whole-person mindset.

And your second point – yes, it doesn't need to be money, does it? It's about the transfer of skills, about what you could offer through your movement locally. If I were still in my old job and you came to me in Wigan, I'd be grabbing your arm to get hold of those volunteers, because they're the people who lead healthy walks, who run befriending schemes, who do intergenerational work with young people. There's lots you can engage those volunteers in – things they're already doing, and things you might want to ask them to get involved with, as citizen experts. So it shouldn't always be about money – it's about thinking of people as assets. You've got some tremendous assets there.

Yes, the gentleman there.

Attendee

Kate, maybe an easier model to work with – let's imagine Cumbria, where I go walking in the Lake District, and you have valleys, so geography becomes quite an obstacle; the same could apply to Devon. So the first part of my question is: how transferable is the approach, given actual physical geography? The other point, which relates to what you said earlier about technology: I live in East Grinstead, and our GP practice keeps introducing more and more technology, more barriers you have to go through, screen after screen – you can't actually go in and talk to a person, you have to go through page after page ruling out symptoms, and some of the questions don't let you put in what your real problem is. So technology seems to be putting up more and more barriers. In Wigan, did you manage to overcome that

obstacle, where GP practices are using technology and actually creating barriers for the end user?

Professor Kate Ardern

Thank you – a wonderful point about Cumbria, which I know very well, having spent part of my childhood there. I always made this point when I was down in Whitehall and they came up with some wonderful model that worked wonderfully if you went twelve stops on the Metropolitan Line, but was no use if you had to go from Kendal to Workington – because, you know, you've got big sticky-up things called fells, and blue bits in between called lakes, meres and tarns; that's why it's called the Lake District. So yes, geography does matter – and, funnily enough, I'm talking to some colleagues in Cumbria at the moment. You'd organise it differently: use some of the principles, but work with the geography you've got, and the natural communities you've got. West Cumbria – Workington, Whitehaven – would be a very different model or way of working to, say, Kendal, or Barrow, or South Cumbria, or indeed Carlisle, which tends to look north or east for things like its clinical networks. So you work with the geography and communities you've got, and adapt – again, not a one-size-fits-all model. Think about what your natural communities of interest are, and what your natural geography does.

This is where technology can be really helpful – what we did was free up staff with iPads so they could work anywhere. AI and digital can help with remote geographies, because they can keep people connected when it's physically much more difficult to get from place to place. Indeed, that's true, and you need good broadband and good Wi-Fi signal in those places – there's an argument for speeding up the rollout of high-fibre broadband into rural communities, because it keeps people connected.

On your second point – yes, we did have alternatives, because you're absolutely right, IT can be more and more of a barrier for people accessing services. It was about recognising that not everyone is digitally empowered or enabled, and having alternatives to that. One of the ways we addressed that was through the weekly huddles we had in all the neighbourhoods, where the neighbourhood manager, practice managers, local police and local head teachers got together – where local professionals met, and comments and remarks, particularly from the VCSE sector, could be picked up and addressed with individual practices. So there was a route to recognising those issues and trying to address them differently.

Sorry – forgive me, we do need to get to some other questions. Very quickly.

Attendee

Did you find that this role reversal took place, where the end customer – the consumer, in this case the patient at the GP practice – had their needs treated as paramount, rather than the needs of the practitioners being paramount, in the way they design and use the technology?

Professor Kate Ardern

Some of that, to be fair to GPs, isn't down to them, but also down to the national rollout of IT. Part of my desire for devolution is that you'd get much more from a more devolved approach to things like IT and AI, rather than a diktat from NHS England saying you've got to use a particular system. For example, Greater Manchester hasn't signed up to Palantir – it's got its own system. And in Liverpool, Ian Buchan, a professor at Liverpool University, works with the Liverpool City Region on their own strategic intelligence system, which looks at the whole of civic intelligence, bringing that broader look at place into focus. Designing much more locally bespoke systems, I think, could be the answer to this.

Great – the lady in blue and white.

Marianne Wanstall

Thank you – Marianne Wanstall, Chief Executive of Tricuro. We're a local authority trading company providing social care services on behalf of a council. You spoke about the importance of that cultural shift, from transactional to transformational commissioning, and how that can help get past the silos that exist. Do you have examples of tactics or methodologies that have worked, in an environment where the strategy of the local authority is very much in the transformational space, but the operational delivery is utterly transactional – where, within the local authority, let alone with other partners, there's no communication between social services, housing, estates, and so on? I'd be interested to hear what tactics have worked, and what's been proven to be successful.

Professor Kate Ardern

I think this is a good example from Wigan. We took the decision, back in 2016, to take our social housing back into the council – quite unusual at the time. We didn't put the responsibility for housing policy where you might think, under the Director of Environment, although estates management was put under Paul, which was entirely appropriate. The responsibility for housing policy came under Stuart Cowley, the Director of Adult Social Care and Health – so we directly put housing into adult social care. Jo Wilmot, one of the deputies, a passionate and wonderful social worker by background, was put in charge of that, and the person working on housing policy with her was one of my team, David Gray. So we put public health back into housing policy too.

That wrapped the whole approach to housing inequality, homelessness and rough sleeping into a package that looked at supporting people into accommodation. It also linked ordinary housing policy with things like supported living accommodation for adults with SEND – quite an innovative approach, and one that's certainly worked well with providers too. Jo has always adopted a very transformational approach to discussions with providers – there was a set of Wigan values providers needed to sign up to, including the national minimum living wage, for example. We also provided things like continuing professional development, really valuing the role of

carers, and investing in care assistants' development – thinking about it as a market development approach to social care, rather than "who can provide the cheapest option?" That's not how it was thought about – it was about wanting high-performing, high-quality social care provision in the borough, because it's about helping people live longer, independent lives. That was at the heart of the policy.

We've just produced – I work with the Restate think tank, as well as the King's Fund and others – a report on the adult social care workforce, on their website, which you might want to look at, and a sister report on funding. Wigan and Lewisham, I think, are the examples we use in that report. If you want to see a report that shows examples of good practice, that's the one I'd recommend.

Thanks very much. Now, the gentleman right at the back who's had his hand up for a while.

Martin McKee

Hi, I'm Martin McKee. You won't be surprised by this question. The examples you gave were great, and will be of huge interest to our colleagues across Europe. Liverpool historically played a leading role in the European Healthy Cities movement, and I'm wondering whether we're taking advantage of all the opportunities to share experiences across Europe, given how many people are facing the same challenges. And on that: if we're negotiating pharmaceutical prices nationally, why aren't we doing it internationally?

Professor Kate Ardern

I'd agree, Martin. We did have an international way of doing things, did we not – quite, I won't go there, the Prime Minister has said enough about Brexit for this week. But yes, there are plenty of lessons from the Liverpool Healthy Cities movement, and I was certainly working in Liverpool at the time that was around, that we probably haven't drawn out and applied as much as we should. Perhaps somebody should write a paper on it, and feed it into the discussions around health devolution – that would be really helpful.

Interestingly, before the pandemic we had a lot of international visitors coming to Wigan – we were on the tourist trail. We had people from Hong Kong, Oslo, Ontario, all over – some even came from London, but there you go. I'll never forget taking William's predecessor, Shirley, up to Sunshine House, and the late, great Barbara Nettleton saying, "I'm really glad you've come today, Shirley, because I've got Hong Kong coming tomorrow." So yes, we need to think about reconvening some of those international networks, perhaps through WHO Europe and beyond, to share learning.

Great – Sarah, from the King's Fund, was next, I think. This is a very knowledgeable audience, Sarah.

Sarah Woolnough

Thanks, Kate – that was fantastic. I want to ask for your best advice on sustaining this way of working over the long term. The King's Fund has, of course, studied Wigan, and Greater Manchester, and Grenfell, and other places where there's this really lively conversation about power, and doing-with, movement-building, devolution – but it often relies on an inspirational leader, or a small group of people, at the core. I'm interested in what you've said about training, and the training you undertook in Wigan. It's interesting – I was talking to some Alaskans recently about the Nuka model, where everyone who goes through it is trained similarly. But I think we're also guilty of defaulting to the same examples, the same set of case studies and places. So what's your best advice for really sustaining something that's still countercultural over the long term, and making it not reliant on a hero leader?

Professor Kate Ardern

Sarah, you've hit on it wonderfully – it is about training, and that's why I'm quite passionate about getting the workforce right. We're still training the workforce of yesterday, never mind the workforce we need today or tomorrow. When we've looked at workforce, we've got a lot of super-specialists – we need super-specialists, but not as many as we've got. We want people to work in communities, in primary care – where are we training them? In hospitals. So where do they end up wanting to work, and where's the pay and reward? There are some thorny issues to sort out in the curricula for medical schools, colleges of further education, and nursing and allied health professions training. There's joined-up training needed with local government too.

I'll give you a great example, from Mo Kumar, a GP in Wigan and the postgraduate GP dean, who came up with a really exciting and sensible idea: teaching boroughs, instead of teaching practices or teaching hospitals – organising training, particularly for undergraduates, around place. What really helped us in Wigan was getting people to go through that induction into place, and get them rooted in what place was about. We designed routes into the training pathway – CPD for GPs, obviously, but routes where trainees were actually taken through and oriented into how the borough worked. The difference that made was quite dramatic.

I'll give you Sanjay Wahi's take – Sanjay's a GP in Wigan. When Chris and Dan came to present their report to the Healthier Wigan Partnership, which went down fantastically, Sanjay, a very thoughtful individual, sat there and said: "Before the Deal, I was really proud to be a doctor, to be a GP, and to work for the NHS. After the Deal, I'm still really proud to be a doctor, still proud to be a GP, still proud to work for the NHS – but I'll tell you what I'm most proud of: being a member of #TeamWigan." I think that's what we've got to get to in people's training, and I think that's why workforce needs to be devolved – because the opportunity to get to place-based training, and things like teaching boroughs, is much easier through a combined or strategic authority route, where you can directly commission universities to do things differently, and partner them with FE colleges. That's what we haven't done in

the past. It means the Royal Colleges have to think differently, the GMC has to think differently too. But we need a different sort of workforce, and different routes into it.

I'd also say that things like the Community Health Champions route are a really good way to get people into health and social care. I certainly saw kids go on to medical school having done that route, and the feedback we got from admissions tutors was that kids who'd done a Community Health Champions health improvement qualification were exactly the sort of student they wanted – they wished more did it. So I think we need a really serious conversation around workforce, and I definitely think we always undervalue the importance of organisational development in HR – I mentioned we changed our HR processes, and that's the route past relying on an individual personality, or an individual inspirational leader. We've got to move away from that, and have things that are sustainable.

What's interesting is that the Deal concept has evolved, as we both know, but it has survived – it's now on its third council leader, and she's very passionate about it, I know Nazia is very passionate about it. It's on its second chief executive, and its second director of public health. In other words, some of the personalities have gone, but the passion and the culture feel like they're still alive. So cultural change is important, workforce change is important, and CPD and undergraduate approaches definitely need to change. Training is important.

Sarah Neville

Thanks, Kate. We're almost out of time – there was a gentleman, forgive me, I think there was a gentleman over here who had his hand up first. Perhaps we can stretch to one more.

Professor Kate Ardern

Yes, happily. Hello, William.

William Roberts, Royal Society for Public Health

We've heard lots of brilliant things about all the great stuff you've done. What's the one biggest mistake you've ever made, that you'd like us not to repeat ever again?

Professor Kate Ardern

Oh, biggest mistake – do you know, and this may sound strange given that I'm a doctor, the biggest mistake I made was going into medicine in the NHS, and not starting off in local government. I worked for the NHS for 27 years and for local government for 14 years, and the most job satisfaction I got, the biggest difference I made, was working in local government. So if I had my time again, I'd probably not be a doctor – I'd probably have gone straight into local government.

Great – one last question.

Dave West, Health Service Journal

Dave West, Health Service Journal.

Professor Kate Ardern

You were very clear about workforce planning being on your wish list, or recommendation list, for health devolution. What's next on the list – what else is on it?

Professor Kate Ardern

Oh, lots of things. I think most health commissioning could be done at a combined authority level. I definitely think we need to think about health protection – a bit of a challenge for UKHSA here, but I think UKHSA risks repeating the mistakes of the Health Protection Agency and Public Health England in its approach to health protection. There are some fantastic people there, and I work with them regularly, but there's a natural tension between managing specialist national assets like Colindale and Porton Down – which I think is what they need to concentrate on, along with developing the new site at Harlow – and managing local health protection teams. I think the lessons from Covid are that we need the whole of health protection, and civil emergencies planning and response, to be joined up.

So I think we need to rethink the tactical layer of public health – the Regional Director of Public Health role, which currently languishes within the ICSs, and probably isn't doing what it could do. Bring it into the mayoral authorities; put things like research and development, health protection and workforce under an expanded RDPH role. In a sense, it's a bit of a return to where regional directors of public health used to sit, in regional health authorities and regional government offices, but updated for the new model of devolution. I think that would be a really exciting bit of tactical development, because strategic, tactical, operational – being an emergency planner as well as a DPH – that tactical layer is often the bit we get wrong, and it's absolutely crucial to get right, because it's the coordinating layer between the thinkers and the doers.

Sarah Neville

Great. At that point, Kate, we'll have to draw this part of the afternoon to a close. It's been fantastic, thanks so much. Now I'm going to hand over to Ben Franklin, who I'm sure will formally allow us to applaud Kate as she should be applauded. Ben is the Deputy CEO of the International Longevity Centre.

Ben Franklin

Thank you so much. Kate, it was an inspiration listening to you. I've obviously read a lot about the Wigan Deal, and heard you speak in small snippets previously in public, but to actually hear you articulate all of your greatest hits, and how they came about, and the processes and people you met along the way, was a wonderful privilege. I don't know about others in the room, but I was feeling a bit

weary coming back to work in September – this has definitely blown the cobwebs away. So huge thanks from me to you for that, and to Sarah, for chairing the discussion so brilliantly. A huge hand for Kate and Sarah, please.

Many of your comments and observations resonated hugely, and there are so many of your slides that we should bottle and send around Whitehall and the nation – but particularly, I thought, your mature approach to devolution at different levels. There's not one fixed rule, and not necessarily one level we should be working on – we should be thinking cleverly about how we can work with people to identify what makes most sense within those places. I thought it was absolutely brilliant; if there's one slide to bottle and send everywhere, that's the big one, for me.

This is, of course, the Sally Greengross Lecture, and I think she'd have been very proud for us to be hosting you today – and I think Gail, one of her daughters, is in the audience as well, which is brilliant. So thank you.

I'm just going to spend a couple of minutes thanking others for organising today's event, and a little plug for future work, before I let you all go for the glass of wine I think you've all deserved and been waiting for. Very quickly: there are lots of partners who enable this kind of event to take place – some, though maybe not all, are on this screen – from across different spectrums, whether healthcare, financial services or government, right across the range of organisations we partner with to make events like this happen. Of course, there are ILC staff who did all the hard work organising today, particularly Hope and Emily – thanks hugely for that. And there are LGA colleagues to thank too – Ronald, Eileen and Charmaine, who helped us out enormously today.

Finally, just a few plugs, if I may, for ongoing ILC work, because we've got lots of ambitious and exciting plans over the next six months. Like many others, we're looking into social care reform, and seeking to be as useful as we can in that space. We recently published something with the Joseph Rowntree Foundation's support on international models of social care, which is well worth a read. We're also doing other work on social care reform, and on devolution and prevention in place – obviously the key theme of today's discussion. We're going to be doing some really groundbreaking work on retirement transitions, and understanding how work and retirement interplay for different groups – watch this space, that will feed into the ongoing Pensions Commission. We're also looking at good work across the life course – we've got a really interesting project, with UK and US partners, on what that might mean, and how we can take a life-course perspective on good work to ensure all workers in 2050 are in a much better place than they are today.

But we're not just UK – we're global as an organisation too. We've got hugely ambitious plans to influence the G20's agenda next year, putting age in the economy at its heart, and of course we're launching the next wave of the Global Health and Prevention Index. That's the final plug for all the activity our team of nine are ploughing on with. We'll also be announcing more details soon about our revamped Future of Ageing Conference next year, celebrating our thirtieth

anniversary. So do keep engaged – there are lots of opportunities for us all along this journey together, and thank you all for coming. I hope you enjoyed the last two hours as much as I did. Most importantly – stay for drinks. Thank you very much.