King's Fund

DEVELOPING PUBLIC HEALTH IN THE NHS - THE MULTI-DISCIPLINARY CONTRIBUTION

The report of a research project commissioned by the NHS Executive

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DEVELOPING PUBLIC HEALTH IN THE NHS - THE MULTI-DISCIPLINARY CONTRIBUTION

1. EXECUTIVE SUMMARY

Introduction

This report explores the multi-disciplinary contribution to developing public health in the NHS. It reports on a research project commissioned by the NHS Executive and undertaken by the King's Fund in 1996. The project comprised a one-day workshop of 32 invited experts in the public health field to identify key issues, and qualitative research consisting of over 30 in-depth interviews in 11 case-study sites in England to explore multi-disciplinary working in practice. This report presents data from the qualitative research; a separate report of the workshop was presented to the NHS Executive in August 1996.

Multi-disciplinary public health: What is it?

The report finds the concept of multi-disciplinary public health working to be widely accepted as a good thing, but little agreement about what it is, or the processes and outcomes that represent this way of working. Section 3 explores the diversity of meanings ascribed to the terms public health and multi-disciplinary working.

The relevance of multi-disciplinary public health

The report identifies why, in the context of the broader changes occurring in today's NHS, it is particularly timely and relevant to look at the opportunities for multi-disciplinary public health. The following themes are introduced in section 4 and returned to in section 8.

The changing role of health authorities
First, health authorities' new responsibilities for the overall health of their local populations mean that they are increasingly seen as evolving into public health organisations. The task now set for public health is to permeate health authority and NHS culture, thus opening the door wide for multi-disciplinary working. In theory, public health has moved centre-stage. However, this report highlights the competing demands upon health authorities.

Organisational changes and new ways of working
Secondly, the massive organisational changes within the NHS in recent years and increased diversity of provision have increased the need for collaborative working, whilst at the same time, making it increasingly complex to achieve. The new NHS thus presents new challenges for multi-disciplinary working. Traditional career paths in the NHS are disappearing. New structures and new ways of working also prompt a

fresh look at the question of where public health is best located. This report finds support for a diversity of models, within and beyond the health authority.

Primary care and public health
Thirdly, as primary care is given an ever more prominent role within the NHS, the primary health care team is increasingly being drawn into the business of public health. Three of the case-studies in this report describe multi-disciplinary public health working in primary care settings.

Professional development issues
Fourthly, the report highlights the poorer education, training and career development opportunities for public health specialists with non-medical qualifications working in public health, and at the resulting differentials in status between those who have medical qualifications and those who do not. The report does not attempt to repeat current professional debates, but acknowledges their relevance.

The core concerns of public health
Finally, the increasingly corporate nature of health authorities raises new questions about the role of public health and what it defines as its core concerns. In the new NHS, is public health a servant of purchasing, or an independent champion of the public's health? On the whole, this report finds respondents optimistic that the two roles can be combined and the dichotomy a false one.

Case-studies of multi-disciplinary working

The core of the report (section 5) contains 19 case-studies to illustrate the range of work identified by research respondents as multi-disciplinary public health. The case-studies give examples of:

- Developing information on local variations;
- New frameworks for purchasing for health gain;
- Priority setting;
- Strategic inter-agency partnerships;
- Community development;
- Multi-disciplinary public health work on mental health;
- Needs assessment in general practice;
- GP forums; and
- Community profiles.

The added value of multi-disciplinary public health

In pursuit of a deeper understanding of what multi-disciplinary public health is about, a particularly useful perspective comes from respondents' perceptions of its added value. The key benefits of multi-disciplinary working (discussed in section 6) are:

- Multi-disciplinary work brings a wider range of perspectives and possible solutions to complex problems. At its best, multi-disciplinary working enables a range of approaches, skills and experiences to be synthesised into a way of working that transcends individual contributions.

- Change is more likely because of wider ownership of problems and their solutions.

- A multi-disciplinary approach can facilitate the incorporation of community perspectives into public health.

- Multi-disciplinary public health work opens the health authority's purchasing to a wider range of professional groups.

- Multi-disciplinary work in public health can lead to better value for money.

- Multi-disciplinary public health can facilitate non-health care interventions for health gain.

- Multi-disciplinary public health can facilitate a more considered response to short-term priorities.

While this report goes some way to indicate a number of benefits of a multi-disciplinary approach, given the diversity of understanding of key terms in this project, and the small-scale nature of the research, it argues that the way remains open for a more detailed investigation of precisely when and how multi-disciplinary working can lead to the greatest benefits. If multi-disciplinary work in public health can be shown to add value, a more consistent and widespread adoption of such an approach could be expected and monitored.

Facilitating multi-disciplinary working in the future

The final part of the report (sections 7 and 8) explores the factors that facilitate and obstruct multi-disciplinary working, and thus identifies the key factors that are likely to progress multi-disciplinary public health in the future.

Acknowledging the significance of informal structures and individual relationships
Firstly, the significance of informal structures and individual relationships in the development of fruitful multi-disciplinary working is identified. Invariably, the project team found that things happened when individual personalities meshed, and in spite of rather than because of formal structures. The significance of individual leaders was also noted. The report recommends that this human dimension of multi-disciplinary working, and the role of what is described as 'creative anarchy' are given greater recognition, and explicit support.

Changes in attitude
Secondly, progress on multi-disciplinary working requires a more open-minded approach to power sharing within health authorities, between professions, and between

professionals and lay people. Professional hierarchies and a culture of tribalism are still dominant features of organisational life in the NHS. Despite widespread support for multi-disciplinary health in theory, the dominance of medicine is still strong.

Improved education, training and career development opportunities

Thirdly, improved education, training and career development opportunities for public health specialists with non-medical qualifications is of paramount importance.

Keeping multi-disciplinary public health on track

Finally, the report acknowledges that resource shortages, short-term priorities, and the demand for health services inevitably place competing pressures on health authority agendas, and can reduce their capacity to progress the complex and long-term task of developing effective multi-disciplinary public health and purchasing for health gain.

2. INTRODUCTION

Aims and structure of the project

In the Spring of 1996, the NHS Executive commissioned the King's Fund to undertake a project entitled *Developing public health in the NHS - the multi-disciplinary contribution.* The aim of the project was to provide the NHS with knowledge on a range of good practice achievable, and to help progress further establishment of good practice in health authorities. The project was conceived in two parts:

- Project A - Issues and basis of good practice.

This was to include a workshop with an invited audience largely drawn from the NHS to identify key issues and the basis (principles) of good practice in multi-disciplinary public health in the NHS.

- Project B - Review of good practice.

This was to provide information on good practice in developing and integrating the complementary contributions of a range of professions and disciplines in multi-disciplinary public health in health authorities and GP purchasing.

The project focused on the purchasing function and described multi-disciplinary thus:

Multi-disciplinary ..... refers to public health specialists from the social sciences, natural sciences, clinical sciences, humanities, environmental health and clinical professions (medicine, nursing and professions allied to medicine) etc., who are working in health authorities (but not solely confined to Service Departments of Public Health), GP purchasing practices or are doing work for them, for example, from a university or consulting base.

The workshop that informed Project A was held on 20 June 1996 and a full report was submitted to the NHS Executive in August 1996. The main value of the workshop, as it happened, identified key issues more than it resolved what was good practice. However, it was a useful event in that it mapped the complexity of the issues, gave a forewarning of the multiplicity of ways of working that were in use, and it gave the project team some important leads on multi-disciplinary public health work that were followed up later in the project. In addition, the workshop discussion served as a reminder that an examination of multi-disciplinary public health brought to the fore a number of familiar and unresolved issues in the NHS. A decision was taken not to rehearse old arguments, but to concentrate in this project on what is new, and developing, in the context of the new health authorities and their development of the public health function beyond 1996.

A full list of workshop participants is given in appendix one.

Project B drew on the discussion at the workshop, and on case study work. Case studies consisted mainly of individual interviews with key people in the selected sites. In health authorities, this was typically the Chief Executive, the Director of Public Health (DPH), and one or two others, including non-medically trained public health specialists. Where we went to a provider, or sought information about the contribution of GPs to multi-disciplinary public health, group discussions were used rather than individual interviews. An account of the methodology is given in appendix two.

The impetus for the project

Public Health in England[1] set out the NHS public health function, and gave a clear statement of public health responsibilities of the new health authorities. (At the time of publication of *Public Health in England*, legislation to merge DHAs and FHSAs had not yet been enacted, but was clearly anticipated in the document). Multi-disciplinary work was implicitly important, as the following paragraph demonstrates:

.... Internal management arrangements will be for local determination, but the resources co-ordinated by the DPH should normally include a full range of staff, including the CCDC, other consultant colleagues in the speciality and qualified support staff. The DDPH should also have ready access to advice from clinicians, including GPs and from other professionals. It is likely that, as the authority evolves into a public health organisation, public health skills will become disseminated more widely throughout the organisation and the DPH will function increasingly as a matrix manager. [2]

There was also a clear view, expressed by the NHS Executive in the project specification and endorsed by many throughout the project, that multi-disciplinary practice and teamwork needed to be strengthened if the NHS is to efficiently achieve local and national health objectives such as the Health of the Nation. Some of this concern had been addressed in relation to nursing, midwives and health visitors in *Making it happen*[3] but the wider context was relatively unexplored, in spite of a rich mix of people from different disciplines working on public health issues.

At the same time, there were a number of indications that the path to effective multi-disciplinary work might not be entirely smooth. Issues of professional qualification, status and career development loomed large. Managerial and organisational models in health authorities and elsewhere had been, and continued to be, in a state of rapid change.

The context of a desire for improved multi-disciplinary work on public health, an awareness that health authorities were, somehow, evolving into public health

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[1] Department of Health (1994) *Public health in England: Roles and Responsibilities of the NHS and other.*

[2] *Public health in England* (op cit) (Annex B, paragraph 3).

[3] Department of Health (1995) *Making it happen. Public health - the contribution, role and development of nurses, midwives and health visitors.* Report of the Standing Nursing and Midwifery Advisory Committee.

organisations, and a sense of both obstacles and opportunities provided a fascinating backcloth for our investigations.

The structure of the report

The report begins by exploring the definitions and concepts underpinning the project (section 3), and then moves on to locate the project within a policy context (section 4). Then, using case studies, we illustrate a number of multi-disciplinary ways of working on public health (section 5). We then look at the contributions that different people bring to multi-disciplinary public health and the added value of such work (section 6), before going on to examine some of the factors that facilitate or obstruct multi-disciplinary public health (section 7). Finally, some thoughts on implications for the future are set out (section 8).

3. DEFINING THE TERMS

A key text on working together for health and welfare[4] describes the field as a "terminological quagmire". This turned out to be both a significant finding of the study and a key methodological difficulty. The task of identifying and reviewing the basis of good practice, as set out in the project brief, was undoubtedly hindered by the fact that the key terms of this project (public health, multi-disciplinary, purchasing) have a variety of meanings for different people. Differing interpretations of the key words of this project were found amongst those working in the same health authority and amongst those from the same profession.

For example, a range of terms are used in practice to describe those without medical qualifications working in dedicated public health professional roles. We have tended to use the increasingly popular term "public health specialists", to describe such professionals, though this is not always commonly understood amongst all respondents.

The variety of working definitions and different formulations of the key issues for the project became evident in the pilot stages of the research. In view of this it was not practical to impose definitions on the respondents. Rather, in order to capture the richness and diversity of people's perceptions of these key concepts, we have used the definitions presented by them. As this issue had been anticipated, to some extent, early in the project, respondents were actually asked to provide definitions for some of the key concepts. In other cases these were explored or noted as they arose.

In this section we explore the meanings of these key concepts underpinning the project and ask:

- What is a health authority's function?
- What is public health?
- What is multi-disciplinary public health?
- What is good practice?

What is a health authority's function?

One of the aims of the project was to highlight notable achievements in the commissioning and purchasing agenda of health authorities involving multi-disciplinary public health. The way that the respondents interpreted the contribution of multi-disciplinary public health to the health authority agenda varied, however, depending on their understanding of the purpose and business of a purchasing authority.

Generally, our respondents used the terms purchasing and commissioning interchangeably, though elsewhere there has been considerable discussion about this terminology. Ovretveit[5] makes a distinction between purchasing and commissioning and distinguishes both of these from contracting. The purpose of commissioning is

[4] Leathard, A. (1994) (Editor) *Going interprofessional - Working together for health and welfare*, Routledge.

[5] Ovretveit, Dr J. (1993) *Integrated Commissioning for Health* Brunel University Health and Social Services Management Programme.

seen as maximising the health of the population by purchasing health services and by influencing other organisations to create conditions which enhance people's health. Purchasing is seen as a narrower activity, mainly concerned with buying health services which provide treatment, prevention, diagnosis and long term care. Ovretveit describes contracting as narrower than purchasing and he says that this involves selecting a provider and negotiating an agreement with them about the services they will provide in return for payment.

One DPH made a distinction between "direct" and "indirect" commissioning, and was keen to stress that public health work which involved exerting influence on other agencies ("indirect commissioning") was equally important as work which informed the drawing up of contracts for health services.

Respondents had mixed views about how far, in practice, health authorities were concerned, not only with purchasing *health services*, but also with the broader role of being champions of the people's *health*. Though many health authorities appeared to define their business more broadly than just health *care*, a number of respondents suggested that much of this was rhetoric, the reality being that the annual round of drawing up health service contracts and the financial issues surrounding this business dominated the health authority agenda.

. . . the main functions of the NHS are about "health care" not "health". Less than 25% is about health [DPH].

. . .there is general agreement between senior executives in [Health Authority] that the policy of maintaining access to services at current levels and avoiding an overspend (which would lead to rationing) is what they should be aiming for. The contracting process has become dominated by financial issues . . . [Director of Finance].

Others have pointed out that, in broad terms "very little can be achieved by writing something into a contract" rather

The real work of commissioning consists . . .of co-operative working, building consensus, networking and influencing across all the different boundaries which exist in the new NHS and beyond to promote the public health and develop better services[6].

Some might see the main business of the health authority as working towards the NHS medium term objectives.[7] Interviewees varied in the importance they attributed to these. Some see them as significant guiding principles;

They are very significant. . . [the Health Authority's] strategy is based on the medium term priorities [Chief Executive].

They are most important. We ignore them at our peril [Chief Executive].

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[6] Goodwin, S. (1996) "Nurses and commissioning" - paper presented to RSH national conference - February 1996 *Journal of the Royal Society of Health* Vol. 116, No. 3.
[7] NHS Executive (1996) *Priorities and Planning Guidance for the NHS: 1997/8.*

Most, however, see them as something that needs to be accommodated or construe what they are already doing in terms of the Executive's priorities.

The Health Authority's role is to meet local needs (derived from public health assessment) as fully as possible while also fulfilling national policies. The Health Authority doesn't take the blinkered view that it is here to deliver national objectives - waiting times etc. Although we do have to consider the Centre and satisfy these requirements [DPH]

We haven't had to pay them too much attention - that's not to say we've ignored them, but we've found the priorities a comfortable fit with what we've wanted to do [Chief Executive].

What is public health?

Searching for a definition

The most commonly used definition of public health is that which originates from Acheson in 1988:

the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.[8]

This definition informs NHS policy and direction on public health[9] and was the one used to introduce the project at the workshop in June 1996.

However, during the workshop and throughout the research, people used different definitions and constantly redefined public health. When we asked people about their understanding of multi-disciplinary public health, they often felt a need to clarify what they meant by public health itself.

The question sets you thinking about definitions of what public health is. There's a distinction between a narrow definition of public health - the technical, scientific public health professional skills, and the wider definition - the health of the public.

Though most respondents referred to the activities or function of public health within health authorities or to public health departments, others did occasionally use the term in this broader sense, meaning *the health of the public*. Throughout the research the term was used rather confusingly.

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[8] Department of Health (1988) *Public Health in England: The report of the committee of inquiry into the future development of the public health function.*

[9] NHS Executive (1993) *Public health: Responsibilities of the NHS and the role of others* (HSG(93)56), Department of Health. NHS Management Executive (1994) *Public health in England: Roles and responsibilities of the Department of Health and the NHS.*

Public health as the work of the health authority
A number of respondents suggested that, as the health authority was becoming a public health organisation, "public health" no longer described the public health department, but rather was the work of the health authority as a whole.

A narrow definition of public health is "the things that we are trained in", but this leads to a specialist, narrow perspective. A wider definition is "our role in improving the health of the public", which is what the HA is about [DPH].

The whole Health Authority and the NHS should be, and could be, influenced by a public health perspective . . .Public health is synonymous with corporacy as it is about collective, not individual, action [Chief Executive].

Public health as a discrete function
Others suggested that public health was concerned with particular areas of work within the health authority, but defined these very broadly.

The different elements are; population health monitoring, needs assessment (including quality), promoting health gain, looking at effectiveness, multi-agency work, partnerships with the community.

Public health as public health medicine
There were also those, however, who viewed public health as the public health (medicine) department within the health authority rather than a function of the health authority.

It depends what definition you use. Public health could mean public health medicine or a broader group of multi-disciplinary staff. It is easier to work with public health medicine as a definition [Chief Executive].

Public health as a political activity
Making reference to the Acheson definition above, a number of respondents were keen to stress that the "art" of public health was as important as the "science" and that the art was essentially a political activity in applying and carrying forward the implications of the science. Executive officers of health authorities, in particular, were concerned that public health people were fully involved "in the messy business of carrying it forward" and did not want an independent technical adviser. A Finance Director said that it was not helpful to have people in the role of advice giver with a "walk on part" saying "I wouldn't do that if I was you" then walking away and leaving the consequences. He, and others, felt that public health ought to be fully involved in the corporate work of the health authority.

There's no room for scientific, expert observers in the Health Authority [Chief Executive].

We do not have a level of isolation to keep ourselves pure! [DPH].

Public health as an advocate for the people's health
Others are not so concerned with whether public health constrains itself to being a technical activity or not, but struggle with the tensions inherent in the role of the DPH as advocate for the public health of the population and their role as a member of the health authority. They are concerned with the potential constraints imposed on the advocacy aspects of their role and whether the health authority can support this role. For example one DPH asks:

Will the Health Authority say there should be a ban on tobacco advertising? The government doesn't want any rocking of the boat on this. Another example is water disconnections. I've said they should be illegal. The test will come if I ask the Health Authority to do something that contravenes government policy [DPH].

The tensions inherent in the DPH role are explored further in section 4. The Department of Health has advised health authorities to state what they believe is influencing the health of their residents on the basis of objective evidence.

Public health as a catalyst
Some saw the role of the public health function within the health authority as pulling together all those working on public health locally and acting as a catalyst for public health work.

Many people are carrying out public health activities, but there is a need to bring these together under a common direction [DPH]

The public health department is the catalyst that makes all this happen [Assistant Director].

Public health - a resource or a service?
One respondent distinguished between public health management and public health practice.

There are two levels of public health work - public health managers who develop strategy and do the commissioning and public health practitioners. Both groups make up the public health function.

Peckham et al[10] note that this distinction between public health as a resource and public health as a service is at the heart of debates about definitions of public health.

Public health as a set of disciplines?
A number of people suggested that public health was an activity based on a range of skills and disciplines. The relevance of skills as opposed to disciplines and the importance, or not, of people's professional background depended on their view and interpretation of multi-disciplinary public health.

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[10] Peckham, S., Macdonald, J. and Taylor, P. (1996) *Towards a public health model of primary care* Public Health Trust.

What is multi-disciplinary public health?

The term "multi-disciplinary" can be understood very differently depending on a number of factors including people's personal perspective, their position in the organisation and whether they choose to take a philosophical or pragmatic line. The term was interpreted in a variety of ways by respondents in the case study sites and by those attending the workshop held to inform the project, some of whom presented definitions of multi-disciplinary public health which challenged the definition given in the specification for the project (see section 2 - introduction above).

There was also a debate about whether multi-disciplinary was to be seen as a way of working - a process, or as a product of the work - an outcome, or both. Indeed was it even possible or desirable to define a multi-disciplinary outcome? These questions have not been explored in depth here.

The range of interpretations attributed to the term "multi-disciplinary public health" included:

- Health authorities employing professionals other than doctors to do public health (a multi-professional model);
- the synthesis of multiple professional views (to produce a "synergistic" outcome);
- public health work that involves non public health doctors, for example GPs and hospital doctors;
- where public health professionals /department are integrated throughout the health authority structure;
- where public health values underpin everything that commissioners do;
- multi-agency, intersectoral, healthy alliance work;
- where the significance of community perspectives are acknowledged in public health working
- shorthand for describing some innovative or creative way of working
- where multi-disciplinary public health is part of a wider philosophy of all health authority work being multi-disciplinary.

Some pointed out that, by its very nature, the practice of public health required a multi-disciplinary approach:

Public health by definition is multi-dimensional - the total is more than the sum of its parts.

Multidisciplinary is multi-professional

The multiple professional model most closely fits the definition suggested by the project proposal and this model was found to some extent in many of the case study sites, whether or not those interviewed chose to define this as multi-disciplinary working.

Our aim has been to extend the range of professionals involved in the public health directorate. We now have a director of public health nursing, a GP (not in the old FHSA medical adviser role but with direct primary care experience); pharmaceutical

public health, dental public health, health promotion, information... etc. [Chief Executive].

Most respondents did not, however, see this multi-professional model as one which represented multi-disciplinary working. It was far more common for respondents to talk about the skills and disciplines required for the health authority public health function, rather than professional background. The other very common interpretations given to multi-disciplinary working by the respondents were that it was working across different directorates of the health authority, that it was multi-agency or intersectoral work, and that it was work that involved community perspectives as illustrated below.

Multi-disciplinary working across the health authority
Joint work across directorates was highlighted by many as what they understood by multi-disciplinary working.

. . .a range of different professions, and these professionals are working alongside people in other directorates who might define themselves as planners, economists etc. [Chief Executive].

. . .we also work together across directorates not just within public health [DPH].

. . . the individual members of staff in the finance department have particular expertise in particular areas, and commissioning managers in the health policy department link with them on particular issues [Director of Finance].

Another Chief Executive described how his Health Authority carried out "inter-directorate work".

Multi-agency or intersectoral collaboration
It is acknowledged that health authorities' responsibilities for discharging the local public health function will necessarily be carried out in a collaborative manner. *Public Health in England (Annex B)* includes "collaborating with local authorities and other agencies" and "developing local health strategies and the alliances necessary to implement these" amongst health authorities public health responsibilities. Some respondents were clear that this was what they meant by multi-disciplinary work.

Multi-disciplinary public health is about the different organisations, sectors and agencies involved in public health. Multi-disciplinary working is multi-agency working [DPH].

People working together with the aim of promoting and maintaining health. This can be statutory and voluntary organisations and individuals in communities [Assistant Director].

One DPH said that the Health Authority had no particular policy on multi-disciplinary work, but rather it was multi-agency work that counts, and that it was important to make alliances.

Others indicated that their definition could include a multi-agency dimension.

In certain contexts (for instance Healthy Alliances) it might mean working with environmental health officers and the Chamber of Commerce. It depends where you want to start and stop with the definition [Chief Executive].

Involving a community perspective
A number of respondents were keen to stress the importance of including the local community in any definition of multi-disciplinary.

Multidisciplinary work involves users [Manager, Public Health Resource Centre].

It is also about the public. This is why the public health department has people working on consumerism [Chief Executive].

[The] public health department aims to be empowering and encourage participation from the local population rather than interventionist [Assistant Director].

One Chief Executive said that it was important to identify the key players in multi-disciplinary public health including users of health services.

Multi-disciplinary - skills and experience
Some respondents preferred not to talk about "disciplines", but felt rather that skills or experience were more important:

Is disciplinary the right term? [Director of Public Health Nursing]

Using a range of skills that are appropriate to the task [DPH]

It is probably better to talk about multi skilled public health rather than multi-disciplinary, as multi-disciplinary work is about drawing on skills and experiences [Assistant Director].

In conclusion, "multi-disciplinary" is interpreted widely, but is invariably seen as a good thing. As one respondent noted "the term is often used as jargon, not defined, but presented as something to which to aspire". The important issues in relation to the public health function seem to be that the health authority should strive to be as participative as possible, have a mix of skills to discharge the function and include a wide range of perspectives on any issue from both inside and outside the health authority.

What is good practice?

It proved impossible to locate an enduring definition of good practice, given the variety of working definitions of these key concepts. In any case what people view as good practice is mainly subjective and will be influenced by a number of factors including whether they are achieving their aims for the organisation, for themselves, for their profession and whether the practice is positively benefiting all those involved, or at

least limiting any harm. There is no consensus on the principles by which "good practice" should be judged.

On the whole, multi-disciplinary working, however it is defined, is seen as good practice. There also seems to be a prevailing view that it is good public health practice to ensure that locally defined health priorities feature in the health authorities' priorities.

4. MULTIDISCIPLINARY PUBLIC HEALTH - THE WIDER CONTEXT

A number of recent policy shifts and ongoing issues, both within and outside public health, impacted on this project. These include:

- the role of the public health function in health authorities,
- organisational changes and their impact,
- the development of a primary care-led NHS,
- the ongoing debate about the role of public health specialists without medical qualifications,
- the most effective focus and location of the public health function.

In this section we briefly summarise these debates and outline their relevance to the project.

Health authorities as public health organisations

In the last decade there has been a steady shift in the role of the public health function within health authorities in England. The Acheson Inquiry was set up in 1986, partly in response to concerns about the role of community physicians following the introduction of general management in the NHS. The report[11] of this inquiry established that there should be a Director of Public Health (DPH) in all health authorities, reporting to the District General Manager (DGM), with a broad remit to monitor and promote the population's health. It was expected, "subject to availability", that this person should be a medical practitioner with special training "in other words a consultant in public health medicine"[12].

However, since then, and as these changes were being introduced, the NHS and Community Care Act[13] has had a major impact, creating the division between purchaser and provider functions and thus enabling health authorities to focus on their responsibilities for the overall health of the local population. The publication of the *Health of the Nation* strategy in 1992[14] provided health authorities with targets in relation to improving the health of the population, further highlighting the importance of the public health aspects of the work of health authorities. Guidance issued in 1993, following the Abrams report, stated the fundamental principle that "public health

[11] Department of Health (1988) *Public health in England - The report of the committee of inquiry into the future development of the public health function* HMSO.
[12] *ibid.*
[13] HMSO (1990) *NHS and Community Care Act.*
[14] Secretary of State for Health (1992) *The Health of the Nation: A strategy for health in England,* HMSO.

considerations must inform all NHS activities".[15] It also reaffirmed the need for health authorities to appoint medically qualified DsPH to assist them in that responsibility.

The publication of *Public Health in England*[16] and *Managing the New NHS*[17] in 1994, unequivocally stated that the goal of health improvement was central to the NHS and confirmed the centrality of the public health function. Health authorities are, in fact, now seen as evolving into public health organisations.

In the context of the evolution of health authorities into public health organisations, we look at the implications for the workforce, in particular the multi-disciplinary aspects of their work.

The upheaval of organisational change

The NHS has undergone massive change in recent years. The pace of that change has increased dramatically in the current decade leading to a complex pattern of local bodies and organisations concerned with health, and commissioning and providing health services. There are an increasing number of administrative boundaries to be negotiated[18] and increasingly diverse sources of funding for health promotion activities. This leads to calls for collaborative and multi-agency working, but makes it more difficult to achieve.

The most recent mergers in April 1996 of health authorities and family health service authorities (FHSAs), the changing role of the regional function from being regional health authorities to regional offices of the NHS Executive, and the new policy thrust towards a primary care-led NHS have all had a further impact on the structure, resources and energy of health authorities. In addition, the introduction (in April 1996) of new unitary authorities in local government have also had an impact on joint commissioning and the development and maintenance of health alliances.

The result of these organisational changes is that much of what was observed during the course of this study was in the very early stages of development. Frequently health authorities had barely settled down from one change to be thrown into upheaval by another. Many of the initiatives described had only recently emerged or had been on hold whilst they rode the tide of the changes.

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[15] NHS Executive (1993) *Public health: Responsibilities of the NHS and the role of others* (HSG(93)56), Department of Health.
[16] NHS Management Executive (1994) *Public health in England: Roles and responsibilities of the Department of Health and the NHS.*
[17] NHS Executive (1994) *Managing the new NHS: Functions and responsibilities in the new NHS,* Department of Health.
[18] Hunter, D. (1990) "Managing the cracks: management development for health care interfaces" *International Journal of Health Planning and Management* Vol. 5, 7-14.

The NHS also reflects general trends in patterns of work. A recent report "confirms that traditional career paths have disappeared" in the NHS[19]. New structures are emerging whereby a small core staff of people with multi-faceted responsibilities are supplemented by others on short term contracts. The tension this brings to achieving a new professional/managerial synthesis is also now evident within health authorities. It seems likely that the current interest in multi-disciplinary working reflects these trends in employment patterns and structures.

The shift towards a primary care-led NHS

The most significant recent policy shift in the NHS is toward a primary care-led NHS. This is the first of the medium term priorities and objectives for 1997-8[20]. This has considerable implications for the role of the health authority public health function in supporting GPs to carry out their public health responsibilities. In some cases, where Total Purchasing Projects (TPPs) are being developed, health authorities are devolving their entire responsibilities for a segment of their local population, including the public health function, to groups of GPs, or TPP Boards largely comprising GPs. The merger of FHSAs and district health authorities provides the potential for public health departments to work more closely with GPs than was previously possible.

Others are currently looking at the implications of a primary care-led NHS for the development of public health. A working group convened by the NHS Executive is considering the key issues and advising on best practice in order to ensure effective public health support for primary care. Others, at the Public Health Trust, are working to develop a public health model of primary care[21]. Their recent preliminary report suggests that for primary care and public health activities to achieve a synthesis, both need to move towards a more multi-professional, participative and collaborative way of working. They argue that both primary care and public health should become less medically focused and more community orientated.

This study has focused mainly on public health in health authorities, though it also looks briefly at multi-disciplinary public health work in primary care.

The professional debate

There is an on-going debate within a number of organisations representing and convening those who work in public health in the NHS about the role of those without medical qualifications. This group of "public health specialists" include epidemiologists, sociologists, public health nurses, health promotion specialists, those with expertise in community development, researchers and others. The issues relate to

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[19] Executive Letter (EL(96)29) from Ken Jarrold, Director of Human and Corporate Resources, NHS Executive referring to *Creative career paths in the NHS - Report No. 5 - Summary of findings and agenda for action.*

[20] NHS Executive (1996) *Priorities and Planning Guidance for the NHS: 1997/98.*

[21] Peckham, S., McDonald, J. and Taylor, P. (1996) *Towards a Public Health Model of Primary Care* Public Health Trust (from Public Health Alliance).

the differential status attached to those working in public health who have medical qualifications and those who do not. The concerns of the latter group include relative lack of training and professional development opportunities, limited career prospects, differential pay and status within NHS public health departments[22].

One focus of this debate has been to argue for the Faculty of Public Health Medicine to accept public health specialists without medical qualifications into full membership of the Faculty. The debate reached something of a climax early in 1996 when a ballot of members of the Faculty resulted in a majority vote against this proposal[23]. The debate continues, however, and a multi-disciplinary Public Health Forum was recently established to take forward the concerns[24].

Whilst recognising that the issues involved in this debate impinge considerably on multi-disciplinary working within NHS public health departments, we do not seek to replicate these debates here.

Where can public health be most effective?

Public health was previously located in local authorities and has only been a health authority function since 1974. There is a continuing and long-standing debate about the most appropriate sectoral location. If the determinants of health are defined broadly, and are to be the focus of public health activity, then many argue that there is a limit to what can be done from within the NHS. Whilst health authorities are still largely concerned with health *services,* public health is inevitably going to be drawn into the managerial and technical functions required to support that activity.

Local authorities are often seen as the more desirable location for public health, partly, it has been suggested, because they are more locally accountable organisations than health authorities and partly because they have the potential to exert considerably more influence on the factors that determine health such as housing, education, social services, recreation, economic development and the environment. In recent years "Healthy Cities" initiatives and "Heath For All" programmes have enabled many local authorities to revitalise their wider public health role.[25] Most recently Agenda 21 initiatives have given a new impetus to local authority involvement in health.[26]

Many, however, clearly see the future for the public health function as being in the NHS and see the current prominence that public health has in health authorities as establishing public health even more firmly within the health sector.

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[22] Somervaille, Dr L. and Griffiths, Prof. R. (1995) *The training and career development of public health professionals - Report of postal survey and discussion workshops.* Institute of Public and Environmental Health, University of Birmingham.

[23] Institute of Public and Environmental Health, University of Birmingham (1996) *Multidisciplinary Public Health - Moving Forward. Report of the 2nd national conference.*

[24] Institute of Public and Environmental Health, University of Birmingham (1996)*ibid.*

[25] Ashton, J. and Seymour, H. (1988) *The new public health* Open University Press.

[26] See, for example, Knight, T. (July 1996) *Promoting health and preventing disease through health alliances in North Staffordshire - Appendix 5 "Linking two agendas"* North Staffordshire Health Authority.

How can public health be most effective?

Finally a continuing and long standing debate concerns the appropriate activities and focus of public health. There is a constant tension between public health as independent advocacy for the health of the local population and public health as a corporate function in the health authority responsible for that population's health. The debate about the most effective of the two roles for public health to play has recently been brought to the core of health authorities as public health has become more prominent in the corporate business of the Authority. Concerns have been expressed since the early days of the NHS reforms, that public health was in danger of being sidelined by a focus on purchasing,[27] and that too great an overlap between general mangers and public health medicine may result in too narrow a strategy for improving the population's health.

Others have argued that public health physicians should engage with purchasing and could do so without necessarily losing their independence.[28] A recent study suggests that while the recent reforms could enhance the position of public health, much depends on the individual DPH and their relations within the health authority. The author concludes that DsPH have to resolve the dilemma of whether they are "in or out of management".[29]

Another observer recently suggested that public health seems to have become overly preoccupied with health service management issues such as clinical effectiveness, priority setting and the rationing dilemma[30]. Hunter suggests that public health needs to focus resources on its core business - the public's health, and not be "hijacked by every passing management fad". He contends that public health is most effective when combining the role of scientist and social reformer. On the other hand, other commentators propose that sorting out rights and entitlements to health care and promoting understanding of the limits to medical care, including the risks, are essential elements of a public health agenda[31].

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[27] Whitty, P. and Jones, I. (1992) "Public health heresy: a challenge to the purchasing orthodoxy" *British Medical Journal* 304, 1039-41.
[28] Watson, P. (1994) "Public health medicine and the DHA" *Journal of Management in Medicine* Vol. 8 No. 1 pp19-23.
[29] Dawson, S. (1996) "In or out of management? Dilemmas and developments in public health medicine in England" in Leopold, J., Glover, I. and Hughes, M. *Beyond Reason? The National Health Service and the limits of management* Avebury.
[30] Hunter, D. (1996) "Reinventing the zeal" *Health Service Journal* 29.8.96 p15.
[31] Coulter, A. Personal communication.

5. MULTI-DISCIPLINARY PUBLIC HEALTH IN PRACTICE

In this section we describe a range of initiatives which illustrate multi-disciplinary public health working in practice. We are not suggesting that the examples given here are necessarily unique or pioneering, but rather we intend to provide a taste of the numerous activities and various settings in which we found multi-disciplinary public health. The case study work focused mainly on purchaser settings, though, as noted above, multi-disciplinary public health work was sometimes defined by those in health authorities as involving people in other settings, such as GPs, provider organisations and agencies outside the NHS.

The examples (case studies) are categorised under a number of headings:

- Developing information on local variations
- New frameworks for purchasing for health gain
- Priority setting
- Strategic inter-agency partnerships
- Community development
- Multi-disciplinary public health work on mental health
- Needs assessment in general practice
- GP forums
- Community profiles

Developing information on local variations in health

Case study 1: Tackling inequalities in Brent and Harrow

In Brent and Harrow Health Authority, as in a number of other health authorities, public health priorities are driven by equity, rather than a narrow approach to efficiency. The public health priorities relate to the large health inequalities in Brent and Harrow, both in terms of health status and experience of the NHS. The ethnicity of the local population is also a strong theme. All the major service strategies, including mental health and acute services are grounded in public health analysis and written from a public health perspective. The public health strategy is not distinct from that of the Health Authority and there is a clear link between previous public health annual reports and commissioning intentions.

Multi-disciplinary partners in this work include local authority colleagues. The Health Authority has joint strategies with both local authorities, and ethnic minority targeted work features strongly here.

Another illustration of how inequalities are addressed is seen in the investment of General Medical Services (GMS) money to address the persistence of the inverse care law.[32] Investment is based on a geographical analysis of need, on health economics analysis and on discussion with GPs in the Local Medical Committee. The analysis uses

[32] Tudor Hart J. (1971) "The Inverse Care" Law *Lancet*, I, 405-12.

population need to determine where money goes, rather than the expressed "needs" of individual general practices.

A further example of a multi-disciplinary approach to public health is "programme budgeting", drawing on a multi-disciplinary approach within the Health Authority. For example, the Health Authority might look at spending on mental health services across the whole spectrum - primary, secondary and tertiary. It is important to this approach that the Director of Finance sees himself as an "investor in health gain", and not just a financial controller.

All these examples reflect the view of the DPH that in public health, multi-disciplinary work starts with the premise that implementation of public health is more than using "sapiential authority" of public health practitioners, that is, the knowledge of social, medical and epidemiological scientists. It is also about using the inter-organisational networking skills of these people and others.

Case-study 2: Public Health Research and Resource Centres

In the North West Region, Public Health Research and Resource Centres complement public health and information teams in health authorities. The Centres exist 'to enable the production and application of public health knowledge within the health service and beyond'[33] and to strengthen the role of the public health function in purchasing. They were initiated in 1991 by the (then) Regional Health Authority, with funding responsibility shared by the Region and the health authorities. Since April 1996 core funding has come from the health authorities, with additional funding obtained from work undertaken on a commissioned basis.

The Centres have two key roles:

- undertaking health intelligence work to guide effective purchasing, and acting as a gate-keeper to health information resources
- undertaking research, evaluations, service reviews, and health needs assessments for purchasers, and providing research support.

The seven Centres vary considerably in size and organisation. In terms of their relationship with health authorities, there are two distinct models. Firstly, the 'in-house' model where the Centre is based within the health authority. The identified advantages of this model are:

- being involved on a day-to-day basis with the formulation and researching of local problems and the implementation of solutions;
- detailed understanding by Centre staff of how the health authority works;
- being 'down the corridor' from where the decision-makers are;
- constantly being aware of the timescales to which health authorities work;
- being around in the organisation to know the right time to argue for and help to implement change:

  Often we do work, and then tend to be disheartened because we don't see immediate change. But often it's a drip, drip effect. If you're still there in the organisation (as we are), then at the right time you can bring it up, you can pick

[33] Ashton, J. (1996) *The health of the North West of England: Report of the Regional Director of Public Health 1995.* North West Regional Health Authority.

your moment. This is what happened with some work on the needs of people with disabilities. We were very proud of it. It involved users at all stages, and we looked at what had been done elsewhere. We came up with a practical list of recommendations. But, it was disappointing, it all went quiet, for all sorts of political reasons around joint commissioning. But now things are starting to happen, and the health authority will start to follow through the recommendations [Manager, Public Health Resource Centre].

Secondly, the 'external' model where the Centre or Observatory, whilst still having close working and funding links with the health authority, is independent, and usually linked with a university department. The identified advantages of this model were to do with work being seen as more credible, carrying more weight, and therefore possibly able to have more impact, by virtue of its independence.

> *Liverpool Observatory, for example, have carried out some joint work on access to services related to various measures of deprivation with EQUAL (Equity in Health Research and Development Unit) for North Cheshire Health Authority. The Health Authority wanted a baseline from which to do something on inequalities. North Cheshire stood to lose out on resource allocations and wanted to bolster their case by showing the level of deprivation. An advantage is that as an external piece of work they can say 'Liverpool University say this .... it's not just us.'* [Manager, Public Health Resource Centre].

An explicit recognition of the value of multi-disciplinary working is a key feature of the Centres. None of the Centres are led by specialists in public health medicine, and the staff employed come from a range of disciplinary backgrounds, with a particular focus on social sciences and social research skills. This composition reflects an emphasis in the work of the Centres 'around the social science end of public health - collating information on people's expressed needs, user views etc.' The Centres have developed particular expertise in facilitating the involvement of local people in decision making about health services.[34]

One Centre summarises the ways in which they foster multi-disciplinary public health:

- by combining different disciplinary skills within the Centre
- by working with medical and non-medical staff on projects
- by demonstrating what can be achieved by "non medical" staff
- by arguing for multi-disciplinary public health at every opportunity.

[34] *ibid.*

New frameworks for purchasing for health gain

Case study 3: PIGs (Policy and Implementation Groups)
The Chief Executive of Sheffield Health sees public health as the key leaders on policy development within the Authority. The name of the directorate - 'Policy and Public Health' reflects this. The directorate leads each of the five 'Policy and Implementation Groups' (PIGs) within the HA. The Children's and Young People's Health PIG is led by the Director of Public Health Nursing, and the Women's and Men's Health PIG by the Director of Health Promotion (the other three are led by consultants in PH medicine). This means that non-medical people are the lead officers in the Authority on certain health areas. The Director of Public Health sees this as an important recognition of the need for a variety of skills, but is aware that it is 'a high risk strategy'. Commenting on having a nurse rather than a doctor leading on purchasing for paediatrics in Sheffield, for example, he suggests:

The test will be the reaction of the Division of Paediatrics - will it matter to them whether this person is a doctor or not? I want them to say after a couple of years 'this person [nurse] does this at least as well as her medical predecessors did - and brings a nurse's insights as well.

Priority setting

Case study 4: Newcastle and North Tyneside
In Newcastle & North Tyneside multi-disciplinary public health work is facilitating the development of a framework to make health authority purchasing decisions systematic and explicit. The framework was derived from joint working between the DPH and health economist in the Department of Public Health. It allows all parties involved to feed into the decision making process using the same criteria to assess various options for which a choice needs to be made. The core criteria are:

- clinical effectiveness
- political priority
- cost effectiveness
- disease burden
- promotion of self reliance
- promoting equity

The purpose of this framework is not to generate hard and fast decision criteria, but to lay bare the implications of, and reasons for, any decisions made. The framework facilitates multi-disciplinary discussion among the parties involved, and reflects the reality that priority-setting decisions are rarely, if ever, clear cut.

The framework has recently been used in Newcastle and North Tyneside to assist in the development of an acceptable policy for ante natal detection of Down's Syndrome.

Case Study 5: Bromley Health

In 1993 Bromley Health's public consultation on their five-year health purchasing strategy revealed a lack of public awareness about the organisation's role in the purchasing and commissioning of health care. In response the public health department developed a structured but flexible, interactive and information giving tool for use with a wide variety of groups, associations and forums in Bromley. They call this the *Public Awareness Raising Tool* or *PART*.

Staff throughout the Health Authority, both within and outside the public health department have been trained to run *PART* discussion groups and have been involved in facilitating groups. The discussion groups have comprised various members of the local population.

PART has four specific objectives:

- To raise levels of awareness about the Health Authority and its role.
- To generate an informed debate and discussion around the need to prioritise within the context of a finite budget, effectiveness and appropriateness and value for money.
- To explore the capacity of this method to capture the views and values of residents on the above using specific examples of purchasing dilemmas.
- To contribute to Bromley Health's organisational development.

The initiative has been the subject of an external evaluation.[35] This found that the *PART* initiative was largely successful in raising levels of awareness about the role of the Health Authority amongst the individuals who participated in the exercise within the various groups and forums, but there was little evidence that this awareness had extended beyond these participants.

Strategic inter-agency partnerships

Case study 6: Strategic health alliances in North Staffordshire

North Staffordshire Health Authority established formal alliances with each of its three local authorities in 1994. The health and local authorities are seen as the lead agencies in these Alliances, though they have been joined by a number of other partners, including the Chamber of Commerce, the Council for Voluntary Service, the Community Health Council (CHC), local colleges, the Citizens' Advice Bureau, the police and a healthcare trust.

The success of the Alliances is seen to depend very much on the extent to which they can operate at a strategic level. It is seen as essential, therefore, that chairs and steering group members are very senior personnel from the partner agencies. Each Health Alliance is co-chaired by a senior executive from both the local authority and the health authority. The Stoke on Trent City Council Alliance, for example, is chaired by the Health Authority Chief Executive and local authority Chief Executive. Others are chaired by the DPH, Director of Commissioning and Directors of Environmental

[35] Milewa, T. and Valentine, J. (1996) *Bromley Health's Public Awareness Raising Tool (PART). An Evaluation.* University of Kent.

Health/Housing. Each Alliance has a co-ordinator who acts as a link between the strategic level steering group and the operational level project working groups. These co-ordinators are employed by the Health Authority and report to a manager in the health promotion department, though obviously work closely with the Chairs of the Alliances.

Sub-alliances have been formed around smoking (North Staffordshire Smoke-free Alliance), physical activity (Physical Activity Advisory Group), and Cycling (North Staffordshire Cycling Alliance). Topic specialists within the health or local authority co-ordinate programmes of work, with public health specialists overseeing "disease" topics, for instance Health of the Nation projects on Coronary Heart Disease and other issues.

The Alliances are seen as the central mechanism through which health strategy can be implemented, and their strategic purpose is seen as working towards truly joint commissioning for health. A strategy produced by the Stoke City Alliance won a regional "Health Alliance" award in 1995. There was some concern, however, within the Health Authority that their potential is not being fully achieved. The Alliances work well as mechanisms for consultation, but are not actually mechanisms for commissioning services. It was also not clear how much money was being spent on activities emanating from the Alliances.

An evaluation report suggested that the Alliances were seen as somewhat peripheral and were not fully integrated with central policy in the partner organisations[36]. It was suggested that some of the partner organisations do not identify their role in promoting health - they still define it rather narrowly. The Associate Director of Health Promotion thought that it might help to change the name of the *Health* Alliances to something like "Quality of Life" Alliances in order that other organisations can see that they have a role.

Case study 7: Inter-agency work on community safety strategy

In Newcastle & North Tyneside the Department of Public Health divides its role into:

- contributing to the corporate agenda, and
- bringing together an effective inter-agency approach.

One key element of its inter-agency work is the development of an Interagency Group. The Interagency Group is now recognised by the Health Authority as the task force to focus and drive forward work in promoting healthier lives in Newcastle & North Tyneside. The existence of the Group is seen as a recognition by the Director of Public Health that partnership at field level is not enough, but also has to be at a corporate, strategic level.

The Interagency Group comprises representatives of both local authorities (including Head of Public Health & Environmental Protection and the Principal Community Education Officer), the Health Authority (DPH, CPHM, Director of Health Promotion and Director of Primary Care Development), Newcastle City Health NHS Trust, North

[36] Knight, T. (July 1996) *Promoting health and preventing disease through health alliances in North Staffordshire* North Staffordshire Health Authority.

Tyneside Healthcare NHS Trust, the Local Medical Committee (LMC) and Newcastle Healthy City Project. The Group sets the agenda of the annual public health report and is responsible for the development of an action plan to monitor progress. For each activity proposed in the public health report, the Interagency group identifies:

- The lead agency
- Who is responsible within the lead agency for action
- Working partners
- Success criteria
- A timetable for action.

For example, one priority identified within the public health report is addressing crime and hardship issues at community level within the context of the development of a published action plan. The Health Authority has been involved in the development of Community Safety Strategies through membership of Northumbria Community Safety Strategy Board. The principal agencies are the local authorities and the police, working with community groups to implement the strategy at neighbourhood level.

Case study 8: Bromley - Partnerships in Health

Bromley Health Authority has a large number of multi-disciplinary projects involving partnerships with a wide range of local organisations including the *Active Lifestyles Project*. This project is a partnership between Bromley Council and Bromley Health. A number of Health Authority staff are involved in this project, including Assistant Director - Health Policy and members of the health promotion department (based in the public health directorate). The aim of the project is to enable the people of Bromley to participate in physical activity and adopt other factors pertinent to a healthier lifestyle.

A major aspect of this programme is the *GP referral scheme* whereby GPs and other health workers, such as dieticians and those in the cardiac rehabilitation department, prescribe a fitness programme, where appropriate, to patients. The scheme is jointly funded by the Health Authority and local authority with some extra funding from the contractors who manage the local leisure centres which has been matched by "Sportsmatch" - a Government (Department of National Heritage) scheme. In addition, £10,000 has been obtained from joint commissioning funding to evaluate the *GP referral scheme*.

All practices have been offered the opportunity to join the scheme and by March 1996 nearly all the GPs in the Borough (except for a few, mostly single handed, practices) were participating. Of 1691 people referred by March 1996, 41% have taken up the "exercise prescription", and of those 423 people (61%) were still active in the scheme or had completed their initial prescription. The project is now recruiting other partners to refer patients, such as health visitors and hospital departments. They are also developing the project in a number of ways, for instance, introducing concessionary rates at the Borough's leisure centres for those who have completed their initial prescription. They are also running training sessions for GPs and others involved in the scheme in order to improve their patients' take up rates.

The *Active Lifestyles Project* is also now targeting women and older people (aged 50 plus), in particular, as they are known to benefit from exercise and to have low levels of participation. This has led to a partnership with Countryside Rangers in order to carry out organised walks, and with a Housing Association to provide health related fitness activities for residents on a local housing estate.

Another scheme within the Active Lifestyles Project aims to encourage the participation of people with disabilities in health related fitness activity, for instance swimming, cricket, football and athletics. The *No Limits Scheme* also involves training leisure centre staff to facilitate access to leisure services for people with disabilities.

Community development

Case study 9: Community development in Bromley

The *Time Out* project focuses on the health of young women in an area of deprivation in Bromley. The population of this area includes a sizeable group of gypsy travellers and the first *Time Out* project particularly focused on young women in this minority ethnic group. A second group was established at a local gym and a third in a local youth centre aimed to attract young mothers.

The notion of healthy alliances - partnerships between different sectors - is central to the project, with local authority and other partners working together with the health promotion unit. "Europe against Cancer" funding was won to employ a health visitor to work as a co-ordinator for the project two days a week, initially for six months. Joint funding was then secured to extend the co-ordinator post for 18 months. The local authority provided a fitness instructor for one of the groups and the Youth services provided support in terms of venues and part-time youth work staff. The Bromley Gypsy Project expressed an interest in the project at an early stage and the Gypsy Support Team (Bromley Education Department) provided specific input in the form of a toy library and literacy support.

The original thinking behind the project was to extend the idea of the GP *referral scheme* (see above) whereby prescriptions were given for exercise, to a Health Visitor referral scheme for sessions which focus on examining what promotes healthy behaviour and providing support for women who want to change unhealthy behaviours e.g. smoking. The project aims to encourage, enable and empower women to take responsibility for their lives and make positive choices for their future direction. It seeks to support women who are involved to develop their skills and identify their own routes to progression, for example through education, employment etc.

The project has been thoroughly evaluated by the South East Institute of Public Health who have made a number of recommendations.[37] They found that the project is a valuable addition to Bromley's health and community service, not only in terms of providing a tangible service to a group of women whose needs are at risk of being marginalised, but - "equally importantly - in terms of creating a different way for

[37] Hodgson, CR. (July 1996) *Bromley "Time Out" Project: Evaluation. Draft report to steering group.* Bromley Health/South East Institute of Public Health.

agencies to work together to create a new approach to community health development". They note that it is important that the project is given "secure funding, clear commitment and tangible support from the agencies involved so that all the stakeholders can reap the longer term benefits of what has necessarily been a labour intensive developmental process".

Case study 10: Community development in North Staffordshire
The three Health Alliances in North Staffordshire (see case study 6 above) have identified 13 *Health Action Areas* on the basis of epidemiological indicators of ill health or socio-economic deprivation. They decided to target community development work in these areas, and, following a review of existing community development projects in the areas, have set up a rolling programme. It is anticipated that each Alliance will focus resources on one or two *Health Action Areas* for a minimum of 3-5 years and then initiate another project towards the end of this period. All the community development projects are set up with the aim of eventually handing over initiatives for self management by the community.

So far part time project workers have been appointed to four of the *Health Action Areas*. The four project workers will carry out health promotion work in a community development model. The first task is to undertake a community profile including participative needs assessment, and to identify local networks and routes for communication They will then set targets for health gain and propose initiatives to meet these targets. These community development project workers operate alongside community nurses and others locally. The project workers are from a mixture of backgrounds and include a psychologist, teacher and nurse.

Initiatives carried out by the community development projects are funded from the Health Authority Health Alliance fund, and from the Health of the Nation budget (the work will undoubtedly impact on more than one key area of Health of the Nation). They also aim to attract external funding.

Case study 11: The William Budd Health Park
The development of the proposed William Budd Health Park illustrates both the importance of inter-agency alliances, and like many inter-agency alliances, it also reflects a community development approach.

The context for the development is a 20-year long history of concerns about health and social needs in South Bristol. There has been a decline in manufacturing industry, and people in South Bristol have had relatively little access to newer jobs. The area is characterised by poor housing stock, comprising both pre-war and post-war council housing. There is also a high incidence of long term ill health, high rates of long term ill health, high rates of smoking, high accident rates and other indications of deprivation. In the area, there are three main health centres, and the Health Authority was looking for ways to rebuild and extend the range of primary care offered. The chance to work towards that aim in a collaborative way was very timely.

In the summer of 1995, the quest for a site to extend primary care by the Assistant Director of Development coincided with the local authority targeting South Bristol for a Single Regeneration Bid (SRB). The Assistant Director of Development contacted

the (then) Avon County Council to see what sites they had for primary care development, and this led to working together on the Regeneration partnership. The partnership with local people is also a key aspect of the development.

The partnership bid suggests a range of services to be developed at the William Budd Health Park over the 7 year period from 1996/7. Proposed services include extended primary health care services, social services, leisure and education facilities.

The early stages of this project provide some useful insights into multi-disciplinary public health. Firstly, there has been close co-operation between departments within the Health Authority. One of those involved in the project noted that there were barriers to beginning multi-disciplinary work, but they were mostly artificial. This project demonstrated most graphically how co-operation between individuals was a moving force, possibly in spite of organisational barriers (although the Health Authority Chief Executive was very supportive and engaged in high-level negotiations). Secondly, the professional backgrounds of some of those working on this project within the Health Authority are useful. One of them, for example, has a background of policy work in local government, and education and R&D experience in public health. Another has wide planning and management experience in the NHS.

Thirdly, the project depends on co-operation between health and local authority. Although this has developed by inter-agency alliance, the idea of co-operation owed something to opportunism and informal links, rather than to formal mechanisms. Initially, the city council did not think of approaching the Health Authority on the SRB. However, their co-operation may result in an imaginative approach to a broad public health agenda.

Multi-disciplinary public health work on mental health

Case study 12: Multi-agency mental health work in Brent and Harrow
In Brent and Harrow Health Authority a multi-agency group was formed to take forward the implications of a report on mental health services written by a multi-disciplinary public health team (comprising epidemiologist, statistical information officers, Director of Community Involvement, GP Adviser). The group included voluntary sector groups (for example, MIND), local authority, Health Authority and mental health service users. Two years on, the group has achieved a number of changes including:

- development of Crisis Intervention Service (CIS)
- development of reprovision units
- sectorisation of Community Mental Health Teams (CMHTs)
- opening of an extra ward
- development of a refugee mental health project
- appointment of a mental health and race trainer
- a review of the way CPNs worked - now they are more generic "community mental health workers"

Case study 13: Developing the primary care response to mental health
Bromley Health have recently established a new post of a facilitator to provide support and advice to primary care teams about developments in mental health and to facilitate practice based developments in mental health. The facilitator, who is a GP with experience in mental health, is also developing the interface between specialist mental health services and primary care teams. Her work includes identification of training needs, development of shared protocols and referral guidelines, facilitating the development of a closer working relationship between primary care and the voluntary sector and liaising with the Active Lifestyles programme in the local authority.

The facilitator is employed by the health promotion department (in the Health Authority) and managed by a Consultant in Public Health Medicine (CPHM). A steering group, comprising two representatives from the LMC, the CPHM, Assistant Director of Community and Priority services and head of health promotion, advises the facilitator.

Needs assessment in general practice

Case study 14: Developing an approach to needs assessment in primary care
Bromley Health are concerned to facilitate the development of general practice-led purchasing. Their current population needs assessment is patch and locality based and relies considerably on national data sets such as the census. This type of geographical data is not generally sensitive or easily translated to practice populations.

The Health Authority public health department has, therefore, developed a needs assessment process that takes into account the views of health care providers, particularly GPs, alongside local residents. It also hoped to develop a means of getting useful information at practice level on the local environment, and other key social factors, such as crime, unemployment, housing provision etc.

Initially Bromley Health have piloted a model for practice sensitive needs assessment at one practice site. The pilot was carried out by a (freelance) project worker with a background in social science and clinical audit. The pilot involved:

- establishing a project steering group made up of key representatives from the Health Authority and the practices involved
- reviewing developmental approaches to needs assessment in general practice settings in other parts of the country
- carrying out a comprehensive data trawl looking specifically at Census data, OPCS mortality and morbidity data, local health surveys on health status, deprivation indicators etc.
- presenting a practice profile based on the data within the local and Borough perspective
- aggregating other relevant data such as prescribing data and community health service activity data
- evaluating the current level and quality of practice level data for use in monitoring the health needs and status of the practice population
- identifying the training needs of practice staff and developing a training package

- developing approaches to patient/consumer communication and to involving the views of health and social care professionals in the process.

The work was carried out over a 18 month period. A draft report of the latter part of this work[38] found that there were some difficulties in sensitising expressed needs to general practice areas. Local people did not have a concept of the "practice area" and either talked about pockets within the area or identified with particular housing estates. It was also a problem that health and social care workers were reluctant to talk about needs beyond their own specialised area, though those outside non-statutory provider organisations (the church for example) and people who lived in the area as well a working there, were able to discuss the needs of a broader cross section of the population.

GP forums

Case study 15: Oxfordshire GPs public health learning set

The aims of the GP / public health learning set are:

- To promote closer understanding and share skills between GPs and Public Health.
- To develop epidemiological and critical appraisal skills among GPs
- To ensure that key policy work has a primary care focus.[39]

The participating GPs applied to become involved with the learning set, and were interviewed as part of a selection process. Those who "succeeded" felt that this signified a seriousness of purpose, and were positive about their experience, although some said they had been surprised at the time at having an interview. The nine GPs who were selected cover a geographical spread, and include both fundholders and non-fundholders.

The process of the learning set is as follows:

- One year course, commencing September 1996.
- Managed by a steering group.
- Launched by the Chairman of the Health Authority.
- Programme to involve individual and group learning.
- Tutors within the public health team run monthly seminars focusing on public health skills, e.g. epidemiology, sources of information, "finding the evidence" and critical appraisal skills.
- Involvement in strategic projects within the Health Authority to enable these skills to be developed. Projects to include osteoporosis, cervical screening and immunisation.
- Formal commitment to the presentation of projects to Health Authority Board.
- Reported as part of the primary care strategy development and implementation, and as part of the four counties Public Health and Primary care network.

[38] Bromley Health (June 1996) *Rapid appraisal of views of professionals and key community informants on health needs in one practice area.*

[39] Taken from internal paper by Sian Griffiths, DPH, Nick Hicks, Public Health Consultant, and Jean Bradlow, Public Health Specialist - Oxfordshire Health Authority.

- Evaluated formally (extent dependant on available funding).

Expected outcomes are:

- Improved public health perspective in primary care to assist in practice and local planning.
- Improved networks between primary care and public health in the four counties.
- Improved opportunities for links with education and research.

Progress to date

This is an initiative in its earliest stages. By October 1996, the learning set had met twice. They have seen what projects might be available, and a semi-formal programme has been set up until November 1996, after which the programme will reflect the needs of the GPs. Some GPs suggested that the role of the Consultant in Public Health should be like any other Consultants, except that the Public Health Consultant could offer a consultancy to general practice. It was anticipated that the learning set GPs would inject energy to "zap up" existing projects. Thus the GP public health learning set provides an unusual opportunity to increase GP public health knowledge and skills, and to utilise GP knowledge, skills and perspectives in shaping the commissioning activities of the Health Authority.

The GPs in the learning set identify the following advantages of their involvement in public health:

a) <u>GPs have local knowledge and know what will work</u>

GPs claimed to know what would and would not work from their direct work with patients, for example, they might have a sense of the disproportionate difficulty in raising cervical smear rates by an additional 1%.

b) <u>GPs need to have ways to influence the Health Authority</u>

Some expressed the view that GP involvement in public health may help to remodel public health departments to fulfil the needs of primary care. GP involvement was also seen as helping the Health Authority to sit down with consultants and get all the perspectives on the table. A non-fundholding GP stated "It was hard to find an alternative way of expressing our views if we did not wish to be fundholders".

c) <u>GPs are the main interface with the public</u>

This was seen as very much a two-way process: as an educative tool for informing patients about rationing and evidence-based practice in the context of a trusting professional-patient relationship, and in informing the Public Health Department where public expectations lie.

d) <u>The advantages of working together with the Health Authority</u>

GPs are the source of information on small populations - health authorities need that information for the bigger picture.

GPs felt that public health can be objective whereas GPs have other influences, not least being their patients. Both perspectives are needed and decisions are more valid if GPs and Public Health are both involved.

Multidisciplinary aspects of the work

It was not immediately clear how multi-disciplinary a focus the GP public health learning set will bring. While the participating GPs felt that they represented the entire Primary Health Care Team, the mechanisms by which they did so were not yet obvious. Indeed, at this early stage of the learning set's life, it was not clear that other practice staff even knew that the GPs were involved in this activity. Nevertheless, opportunity to increase the multi-disciplinary component was potentially there, and the involvement of GPs themselves adds another set of perspectives to a Health Authority's work.

Case study 16: New River Total Care Project (TCP)

New River is a Total Care Project covering a population of 60,000, and comprising five practices in Enfield and Haringey in North London. The TCP is managed by a Board, with 10 voting members: five GPs from the participating practices, two Health Authority non-executive members and three Health Authority executive members. There are also up to 13 non-voting members, for example, a representative from the Local Medical Committee, representatives from the Community Health Councils, a nominated representative from each of the local authority Social Services Departments, the co-ordinator of the TCP and five practice managers.

The TCP is interested in getting the Public Health Department in the Health Authority to take on a perspective from the GP practices. The Project Co-ordinator has a Masters in public health and used to work in the local Public Health Department evaluating progress on Health of the Nation and facilitating the implementation of local targets. (He also has experience of managing a primary medical care centre in Chicago). He sees that there is an issue about what GPs can bring into the Health Authority's Public Health Department, as well as how the Health Authority Public Health Department can influence GPs.

The TCP has attached to it a registrar in her last year of public health training. This arose mainly from the interests of the Registrar, rather than from a pre-existing recognition in the Health Authority that they needed public health input into primary care. The Registrar is trying to get public health into primary care, in a number of ways, including the following:

- Needs assessment - guiding developments to ensure that they are based on assessments of need.
- Developing a health strategy for the TCP - this is being done at present.
- Evaluating developments - developing objectives and working to these.
- Providing public health advice to the Project. For example, GPs were interested in "Hospital at Home" schemes. The Registrar carried out a literature review and service review and directed GPs to the sources.

In common with the Oxfordshire GP public health learning set, (see Case Study 15 above), GP commissioning priorities appear to be more rooted in practice. GPs tend to base their knowledge on personal experience rather than scientific evidence alone. GPs are keen on action-oriented solutions. For example:

a GP will write one letter to ask a nursing home to provide more beds for his patients, whereas the Health Authority would write a 57 page strategy about the provision of care for the elderly [TCP Co-ordinator].

The TCP's commissioning plans may be less influenced by the NHS Executive's medium term priorities than is the Health Authority, though the GPs' priorities do tend to mirror NHS Executive Guidance. GPs may also tend to take a much shorter term view than the Health Authority. Health authorities have to take a broader view, in contrast to the GPs' concerns about patient profiles and individuals.

The TCP Co-ordinator suggested that, whilst the different approaches of GPs and health authority public health departments could be complementary, some of the differences in emphasis caused problems to the working relationship. One such issue is that that the Public Health Department tends to take a geographical perspective - "the Project is trying to change that somewhat". Also both the Co-ordinator and the public health registrar found themselves "straddling" the Health Authority and GPs on many issues. The registrar, in particular, found this was a difficult role, though pointed out that sometimes she was able to satisfy both parties, for instance in the evaluation of the GP out-of-hours co-operative she was carrying out.

There are, however, potential and actual mutual advantages to having the TCP's involvement in public health. The development of a public health strategy for the project is a notable achievement. The strategy has encouraged more long term (strategic) thinking, and has helped the GPs focus on Health of the Nation, patient participation, and evaluation. The Project also hopes that the Director of Public Health will recognise the need to get primary care issues into public health, to increase the awareness at Health Authority level of grass roots needs. The Project sees that localities need to be served as well as implementing global strategies.

The TCP Co-ordinator felt that the Project has already demonstrated that such projects can manage to commission services effectively, but stressed that the health authority will always be needed to define the context within which this happens and to give the whole population view:

The health authority will provide an overview and check that the various locality strategies are in tune with the others [TCP Co-ordinator].

In the future, he felt, public health should be providing GPs with the tools and knowledge to carry out public health function in their practices. For example, they could design better databases for GPs to collect the information that they need in order to have a public health perspective on their local area. This information could also be fed back to the health authority and used to inform their perspective.

Community profiles

Case study 17: Practice profiling in North Downs Community Trust
In North Downs Community Trust, in Surrey, the community nursing teams were able to identify a large number of public health activities undertaken by Health Visiting and

District Nursing teams and targeted towards the public at large. Many of these activities related to Health of the Nation initiatives, and included screening, counselling, clinics, groupwork, practical measures e.g. loan of equipment, health education and health promotion. In addition to the Health of the Nation areas, Health Visitors and District Nurses were active in a large number of clinics, services, groups and projects, including Practice Profiles.

Practice-based nurses and health visitors are involved in "practice profiling" across 56 practices. A practice profile is a report on both services and the health needs and status of the practice population. The aims of practice profiling are as follows:

- to identify need and unmet need
- to identify the strengths of the service and to encourage reflective practice
- to assist in the development of appropriate professional skills
- to clarify where to focus energies
- to inform the business planning process
- to influence social policy
- to influence resource allocation
- to contribute to re-thinking of priorities

In addition to basic information about the practice and practitioners, the profiles include sections on age-related population statistics and birth statistics, current local issues, environmental issues, housing provision, clinic and screening sessions, progress towards, and achievement of, Health of the Nation targets, an evaluation of the previous year's objectives and an action plan for the current year.

How practice profiles contribute to commissioning

The profiles contribute to an understanding of population health and have an impact on commissioning. The Clinical Team Leaders were initially very diffident about the possibility of changes in commissioning or prioritisation as a result of practice profiles, and initially saw profiles mostly in terms of relating staff skills to practice need. To date, however, it appears that practice profiles have influenced a number of significant changes in commissioning and provision of services, including the following:

a) Terminal care - increased provision of services and improved staff training
b) Post natal support groups
c) Sitting service for elderly people and palliative care clients
d) Godalming Crisis Intervention Scheme - to prevent acute admissions
e) Sexual health project
f) Safety at home project
g) Joint funded projects e.g., bathing schemes and an alcohol reduction project.

Practice profiles are also becoming influential in justifying new bids for joint funding. One of the Clinical Team Leaders suggested that practice profiles could be seen as "marketing tools". It was also suggested that some GPs were beginning to move money around, as a result of practice profiles, although this was a slow process.

Practice profiles have become more important since contracting entered the NHS. The team identified a number of ways in which they see practice profiles as "ahead of the game":

- Practice profiles collect information "bottom up".
- The use of profiles to influence purchasing is "more sophisticated than we realised". There was a feeling in the team that practice profiles should become more integrated into business planning.
- Money is starting to flow back into the Trusts as a result of practice profiles.
- Practice profiles encourage research that "focuses upstream" i.e. towards understanding and tackling the causes of ill health.

Multi-disciplinary aspects of the work

The community nurses found the concept of multi-agency more relevant than multi-disciplinary, and, though they did not have an explicit or agreed definition of what multi-disciplinary meant in the context of their work, they saw that they worked with other agencies, such as Housing, Environmental Health (local authority) etc. and they recognised the multi-disciplinary aspects of that.

Practice profiling was seen as a multi-disciplinary activity, though the point was clearly made that the multi-disciplinary aspect varies greatly between practices. It also seems to be the case that the multi-disciplinary aspect of actually compiling the profile is within a narrow range of disciplines, i.e. medical and nursing. At its best, everyone who works in a practice - doctors, nurses, health visitors - sits down together and decides who will complete which bit, and then everyone completes the bit that they have agreed. The consensus was that the better the teamwork in the practice, the more useful the profile was likely to be. Practice profiling requires team work, and sometimes assists team building as it necessarily involves co-operation across all disciplines.

The networking that takes place around profiles is useful. Profiles collect information not just from within the practice, but also from boroughs and voluntary organisations. Crucially, they also feed information back.

Finally, the profiles are seen as the basis for Development Profiles. Development profiles have been used for two years to describe the generic and specialist skills and knowledge that nurses need to meet the needs of the practice population. They are also used as the foundation for considering personal competencies and developing appropriate needs-related professional skills.

Case study 18: Health visitors and action plans in Sheffield

Sheffield Health is the first health authority in the country to appoint a Director of Public Health Nursing, reflecting its aim of extending the range of professionals involved in public health. The Director of Public Health Nursing is currently developing a (draft) service specification for the public health function of health visitors in the local trust, within which it is made explicit the sort of public health service Sheffield Health wishes to provide for the people of Sheffield.

The aims of a public health service in primary care:

- To identify the health needs of populations
- To work with other agencies on public health action to promote and maintain the health of populations

- To minimise the health impact of social deprivation
- To identify and develop the resource capacity of communities.

The service specification illustrates how purchasers can stimulate the development of multi-disciplinary public health action at a community level. It requires health visitors (employed by the local trust) to work in partnership with local GPs, Sheffield Health locality teams, other agencies and local people to develop a three year public health action plan. Public health action plans will be focused on the following objectives:

- promoting social regeneration
- developing social support networks
- increasing resources for health
- improving environmental conditions
- increasing access to services
- achieving community participation

The action plans will become a resource for locality commissioning, and more widely, for local people and health professionals.

Case Study 19: Using health visitor profiles in Hillingdon

In Hillingdon Health Authority, the Associate Director, Primary and Community Health (a former health visitor) has written a requirement into the contract with her local trust to be supplied annually with a copy of every health visiting profile. This is an example of how provider information about health needs, put together by health visitors who understand the connections between need, social factors and public health, and the supply of primary care service provision, can and does directly influence the commissioner's health strategy formulation'.

Some local health visitors in Hillingdon, working in an area where primary care teams were poorly developed, were concerned about the closure of a clinic at the same time as a growth in the population on a housing estate. They put together a community profile, which identified the need for another GP in the area. The profile also contained information based on data routinely collected by health visitors in the trust regarding single parents, ethnicity and unemployment, as well as things like milk token use, clinic attendance and distances travelled to local GPs. The profile was used by the Health Authority to inform work with the local authority on what services should be developed on the estate, to argue the case successfully for another doctor being allowed to practice in the area, and also resulted in GPs on the estate being invited to join a local primary care team building initiative.

Building upon this community information gathered by health visitors, a former town planner in the Department of Public Health at Hillingdon Health Authority has subsequently drawn up a multi-disciplinary plan for reviewing the health needs of the people living on this estate and others in the locality, and their access to good services.

6. THE CONTRIBUTION OF MULTI-DISCIPLINARY PUBLIC HEALTH

Introduction

In section 3, *Defining the terms* the definitional variations of "multi-disciplinary" are discussed. In this section, we firstly examine the contribution made by those with particular professional backgrounds, skills and expertise to public health, and then secondly, we explore the added value that a multi-disciplinary approach brings to public health, having regard to the fact that our respondents had many and varied ideas of what they understood by "multi-disciplinary".

What people bring to multi-disciplinary public health

Our respondents identified an extremely wide and varied range of attributes that people brought to public health. These included different skills, backgrounds, education, expertise, influences, perspectives, knowledge, experience, interests, qualities and disciplines:

Its about bringing a range of experience, expertise, skills, not just about professional disciplinary background [Director of Public Health Nursing]

The qualities and experience of the individual person are as important as their training or skill [Assistant Director].

One DPH said that the health authority public health function needs different contributions for different purposes, including good epidemiology and clinical skills, an understanding of patterns of care and someone who can talk to clinicians and the public.

Where people are coming from
People's backgrounds were seen by some as important because of the extra dimensional perspective that they could bring. This was viewed as particularly useful if they had experience of service areas outside the traditional remit of public health or different ways of working to that found in health authorities in the past:

I bring a strong understanding of public policy agendas. Of different ways of doing things. . .I bring not just my professional background, but my experience in local government - an understanding of the planning department . . . how it all works together [Health Authority Primary Care Project Manager]

My perspective has come from my background in public health as a provider . . .it is not just the professional background. Its the analytic perspective. Its about being a nurse, experience in primary care, sociology, knowing about children [Director of Public Health Nursing]

. . .in addition to different skills, colleagues bring different health service experience [Manager, Public Health Resource Centre].

The Chief Executive of one health authority noted that some people brought practical experience and a different perspective from their background of working as GPs or in Trusts.

What people can do

Skills and abilities were also constantly referred to, both "different skills" and "specialist skills". Skills are often viewed as specific and technical:

We (public health) bring sound technical abilities. Numeracy with epidemiological data, clinical trials, performance monitoring, NHS data [DPH].

Those with medical qualifications were not always seen to have the monopoly on these skills:

As an academic, I can bring rigour, ability to be objective. The technical bits about public health research methods. Also research ethics - an understanding of the power relationships in research. Doctors are often not very good at that [Manager, Public Health Resource Centre].

On the whole, respondents thought that there were few areas of public health where someone actually needed to be medically qualified. Even where clinical knowledge and skills were seen to make an important contribution to public health, this related to doctors having experience of clinical practice, rather than specialist medical knowledge:

The key issue is having had clinical contact with patients [DPH]

Doctors bring a clinical understanding. They're at home with a lot of the clinical information which we are not, and don't need to be. And an understanding of how hospitals work [Manager, Public Health Resource Centre]

It is also useful that they have the experience of working on the ward and experience of making choices about patients [Assistant Director].

Skills can also be about working in particular ways, for example change management skills, political skills, training skills or ability to involve the public:

Public health needs people with change management skills and political skills. These are core skills which everyone should have in addition to whatever specialist skills or knowledge they bring [Assistant Director]

. . . the task is essentially a community development one. We need people with the skills to address the question: what is the health scene? What are the local resources? How can we catalyse, stimulate? [DPH].

The added value of multi-disciplinary public health

There are three major difficulties in understanding the specific added value of multi-disciplinary work in public health, rather than the generalisations. One is that job titles may give only the scantiest clue as to the nature of an individual's actual job. The second is that what individuals bring to bear on the public health function may reflect current role as much as it reflects the particular background or professional training of that individual. As we shall see, in some instances, the added value of multi-disciplinary work is a result of bringing very particular analyses together in a synergistic manner.

However, in other instances, the organisational and corporate needs for staff to be flexible make it more difficult to track what a particular member of staff offers in terms of a particular training or discipline. A prevalent view was that multi-disciplinary working was mostly a question of different roles (or jobs), rather than different skills, except for the Consultant in Communicable Disease Control (CCDC), which was often seen as rather specialist in terms of personnel and skills. The third issue is that the starting point of any discussion about multi-disciplinary work is, invariably, an unquestioning assumption that multi-disciplinary working is a good thing. The result is that the reasons why multi-disciplinary work is good, and what added value it brings, may not previously have received much attention. As Kitson[40] has argued:

We have the rhetoric of team work but not a prevailing deep understanding of it.

What our respondents have in common is a set of opinions about the value of bringing different perspectives to bear on a problem, whether those different perspectives are individual, professional or organisational. They suggested a number of ways in which multi-disciplinary work was valuable.

Multi-disciplinary work brings a wider range of perspectives and possible solutions to complex problems

One of the chief advantages of multi-disciplinary work in public health is the opportunity that it affords for bringing a range of ideas to bear on complex issues. Different professional background and skills suggest a range of approaches. This is particularly important where a wider view of public health is taken. As one respondent stated:

Public health is lame in the extreme if it is only medicine [DPH].

It follows that if public health is in itself a broad discipline, then medically qualified personnel can only contribute part of what is required. Another Director of Public Health puts this plainly:

A problem has to be defined as broadly as possible to provoke as broad a response as possible [DPH].

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[40] Kitson A (1995) "The multi-professional agenda and clinical effectiveness" in Deighan, M. and Hitch, S. (Eds) *Clinical effectiveness: From guidelines to cost-effective practice*. University of Manchester.

A Director of Public Health Nursing sees multi-disciplinary working as looking for multiple solutions to problems, rather than being single-dimensional. In particular, she values the mixture of public health analysis with public health action.

This view is also implicit in the view of one public health specialist. She notes that one needs to have a multi-faceted way of looking at an issue:

For example, if you sit around a table with a GP, nurse, youth worker, environmental health officer and someone from the chamber of commerce to discuss smoking in young people, you will get a very different picture than if you just involved the public health department. This kind of multi-disciplinary input is very important given the new responsibility of health authorities for health (not just health services) [Public health specialist].

In so far as this approach implies the need to be open to gaps and other ways of thinking, the benefits of training in disciplines other than medicine may be particularly beneficial. Some would assert that medical training does not encourage doctors to see problems in this complex and multi-faceted way. Sometimes, it is those with medical training that are most forthright about the limitations of a doctor's perspective. One DPH believes that multi-disciplinary work avoids "stuffiness". He also contends that:

[non-medically trained staff] take the broader view when we [doctors] are hung up on detail [DPH].

A Chief Executive makes the point that a multi-disciplinary approach can dramatically affect the focus of discussions on what can be achieved and how things can be achieved. Thus a multi-disciplinary approach contributes to discussions of the wide range of determinants of health and diverse models of service delivery. In this Health Authority a multi-disciplinary perspective leads to a wide approach to tackling the variations in risk from CHD in different areas of the city. It has, for example, contributed to the establishment of a health action area, involved with urban regeneration.

Benefits of multi-disciplinary work may also accrue to individual workers. A Resource Centre Manager sees that in addition to being able to articulate all the different skills in the context of a particular research question, people from different disciplines also individually learn from different perspectives and approaches.

Sometimes, multi-disciplinary work brings necessary differences in emphasis that lead to what is, at its best, a creative tension. One Chief Executive observes that public health brings epidemiology; "a macro approach", research evidence and analysis, and tends to be oriented towards a grand plan. Others may be driven by shorter term objectives:

Sometimes I have to tighten the rein to a practical short term goal [Chief Executive].

Arguably, a range of disciplines, not only within a Public Health Department, but within the health authority as a whole, allows a higher level of debate on the best ways to fuse long term ambitions with short term imperatives.

Interestingly, GPs are among the most vociferous proponents of this view in making out the case for their own involvement in Public Health, alongside doctors with a specialist public health training. (See case studies 15 and 16, Section 5, which describe the Oxfordshire GP public health learning set and New River TCP).

Change is more likely because of wider ownership of problems and their solutions
Multi-disciplinary working tends to mean that the stakeholders of a particular initiative are actively involved, and, therefore, more likely to be committed to it. In North Downs Community Trust for example, where a range of disciplines contribute to practice profiles (see case study 17), the multi-disciplinary aspects of the work are evident not only in the production of practice profiles, but also in the use to which they are put. In fact, the multi-disciplinary aspect of the application of the intelligence in the practice profile is larger than the multi-disciplinary input into the profile itself, in so far as non-medical and non-nursing people use the material in the profiles to a greater extent than they contribute to it. However, the credibility of the information owes a lot to the fact that many different members of the team have contributed to it.

Elsewhere, the development and implementation of the eligibility criteria for continuing care was cited as a good example of multi-disciplinary work. It required the input of clinical medical staff, nursing staff, health service managers, and personnel from social services, housing and the nursing homes inspectorate to ensure that all the relevant ground was covered prior to the criteria being developed. In this instance multi-disciplinary working meant that a common goal was identified to which everyone was committed.

In Oxfordshire, the GP public health learning set hopes and expects that the involvement of GPs may cascade through to others, such as the nurses, in the Primary Health Care Team, and present a more uniform front to patients.

A multi-disciplinary approach brings in user and community perspectives and is necessary in order to bring in those perspectives
It has been noted that there is a range of implicit and explicit definitions of "multi-disciplinary". The broader views encompass lay views alongside professional views. Respondents' views reflect those found in the literature, where many commentators in recent years have argued for the inclusion of user and community perspectives in public health analysis. Davison et al.,[41] for example, identify the potential for health professionals to learn from a sophisticated "lay epidemiology". And Williams and Popay argue that:

If public health research is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, and contribute to more

[41] Davison C., Davey Smith G. and Frankel S. (1991) "Lay epidemiology and the prevention paradox" *Sociology of Health and Illness*, 13, 1, 1-19

effective preventive policies, then it must utilise and build on lay knowledge - that is the meanings illness, risk, disability and so on have for people[42].

If one takes the view that involving lay people and hearing their views is important, (and the NHS Medium Term Priorities reinforce this view)[43] then it is necessary to consider how best to have the necessary dialogues.

A view expressed by an Assistant Director is that specific training in public health medicine does not necessarily equip someone with service review skills or community engagement skills. Her view is that doctors could talk to groups in the community, but it is not likely they would do it very well.

The Resource Centre interviews highlighted the view that social scientists have particular skills and training in eliciting the views of users. Williams and Popay[44] argue not only for the pivotal role of lay knowledge in contributing to the public health agenda, but also the recognition that this knowledge requires social science methods in order to make it visible and accessible.

Multi-disciplinary public health work opens the health authority's purchasing to a wider range of professional groups

The role of nursing in public health has already been recognised[45], though it undoubtedly has further development potential. A Director of Public Health Nursing argues that multi-disciplinary working helps to open up the health authority to other professional groups such as nurses. This means that those professional groups perceive the health authority as more accessible and it brings the purchasing function nearer to them.

In addition, multi-disciplinary work can include a much greater variety of professionals. For example, Directors of Finance play a key role in health authorities, and their contribution can be valuable to the public health function.

Multi-disciplinary work in public health leads to better value for money

Although several respondents claimed that multi-disciplinary public health helped health authorities get value for money, they mostly referred to the role of the public health function in debates about effectiveness and evidence-based practice, rather than making out a specific case for the multi-disciplinary aspects of the public health function in relation to cost effectiveness. Thus, for example, one health authority had altered health visitor staffing on the basis of caseload weighting, effectiveness and needs. In this Health Authority, the Public Health Department had had a large role in debates about rationing, and had "withstood onslaughts", such as demands for prostate cancer screening, and population-based DEXA scanning for bone density, all on effectiveness grounds.

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[42] Williams G and Popay J (1996) "Social Science and Public Health: Issues of Method, knowledge and power" *Critical Public Health*, 7 (forthcoming)

[43] NHS Executive (1996) *Priorities and Planning Guidance for the NHS: 1997/98.*

[44] Williams and Popay *op cit.*

[45] Department of Health (1995) *Making it happen - Public Health - the contribution, role and development of nurses, midwives and health visitors.* Report of the Standing Nursing and Midwifery Advisory Committee.

In another health authority, the DPH leads the Priorities Forum, which determines, among other things, what the Health Authority will not purchase.

A further aspect of value for money is that, arguably, the broad range of skills that public health specialists bring are indeed, cost effective. Naturally, it is important that value for money, rather than simple cost is taken into account. It is equally important that where doctors are needed for their particular skills, then they must be utilised, rather than a possibly cheaper but less appropriate alternative.

A number of respondents felt strongly that people should retain their own skills and not try to become something else:

Non-doctors should keep their skills - not try to become doctors [DPH]

. . . there should be respect for the expertise of others - including doctors' expertise [Assistant Director].

Multi-disciplinary public health can facilitate non-healthcare interventions for health gain

One important aspect of multi-disciplinary work in public health is the building of alliances with people outside the health authority, and the encouragement of collaborative and co-operative initiatives to increase health gain. For example, in Sheffield, the Public Health Department works closely with the local authority traffic unit. Traffic calming areas have been introduced and in two years there have been no accidents in these areas which were previously bad spots for accidents.

In Brent and Harrow, work on Coronary Heart Disease prevention includes discouraging people from using cars, which is seen as being as important as making contracts for cardiac surgery. The DPH refers to the need for "indirect commissioning" - providing alliances and support for others.

In North Staffordshire, the Health Authority lead healthy alliances which have supported community development programmes and these are now a major programme of work.

As one DPH indicates, it is a debatable issue whether health authorities should spend money on non-health care interventions. On the one hand, it is a powerful way to spend money if the determinants of health lie outside the health service. On the other hand, only health authorities have a budget for health care whereas others can spend on non-health care interventions.

Multi-disciplinary public health can facilitate a considered response to political imperatives

The importance of a strategic approach was underlined by many of our respondents. For example, in 1994-5, Oxfordshire Health Authority published a health strategy, in which there were 3 key questions: Where are we now? Where do we want to be? How are we going to get there? - These 3 questions were asked in relation to both care

groups (e.g. elderly) and common clinical conditions (e.g. stroke). The public health specialist describes this approach as "signposts for future development". She also says:

The stronger the health strategy, and policies, the more the rest fits into place [Public health specialist].

She, and others, also expressed the view that the Public Health Department has a health focus; the rest of the organisation may have more of an operational (and centrally-driven) focus.

It would follow from this that if there is a greater degree of multi-disciplinary work, there will be a greater ability to respond to short term imperatives in the context of a steady public health strategy, to which the whole health authority can subscribe. At the very least, the multi-disciplinary commitment to strategy can bring health authorities back on course when they are blown in other directions by political, fiscal or other urgent forces.

Another Chief Executive explains that every now and then, political imperatives come to the fore, e.g. emergency care and ITUs, beta interferon. These can skew local priorities. Having multi-disciplinary public health values underpinning the work helps, because it allows the Health Authority to make a more considered response to these imperatives.

Summary

Multi-disciplinary work is sometimes construed very narrowly, for example as the inclusion of non-public health trained doctors; sometimes it is construed widely to include lay people. There are many shades of grey between these views. On the whole the contribution different people make to public health should be seen largely in terms of the roles they currently play rather than the different skills or backgrounds that they had. The perspectives that people bring from their previous experience is probably more significant, in contributing to the multi-disciplinary whole, than the knowledge or skills attached to a particular discipline.

In most instances, multi-disciplinary work is seen to be an added value in public health because it is a way of addressing complex, multi-faceted problems by complex, multi-faceted analysis and action. The involvement of many disciplines seems to be important in strengthening the corporate aims of a health authority, in delivering a considered, strategy-based, cost effective response, in the face of possible diversions.

7. FACTORS FACILITATING AND OBSTRUCTING MULTI-DISCIPLINARY PUBLIC HEALTH

Introduction

Conceptually the research team identified two distinct dimensions of this project. The relationship between the new health authorities and the public health function, and the development of multi-disciplinary public health. Our approach to the case studies reflected this (see methodology - appendix two). These two dimensions are not necessarily interdependent, though they do overlap. Our respondents sometimes found it hard to separate factors that facilitated multi-disciplinary public health from those which facilitated the health authority to move towards becoming a public health organisation. This fact, in itself, suggests that there is some validity in the assumption that a broader multi-disciplinary conception of the public health function will better facilitate health authorities to be public health organisations.

In this section we first explore the range of relationships between public health and the health authority found at our case study sites, and the factors that influence these relationships. We then explore specifically the factors facilitating and obstructing effective multi-disciplinary working.

The range of relationships between public health and the health authority

Public Health in England[46] states that a strong public health function would be needed in each health authority, led by the Director of Public Health (DPH), and goes on to note that a close working relationship between the DPH and the Authority's Chief Executive is essential. It was considered crucial to an understanding of multi-disciplinary public health in health authorities to examine these working relationships at the case study sites. Though the organisational charts and structures were examined on paper, an important finding was that informal relationships and structures were probably more important than formal ones:

Informal structures are possibly more important than formal ones. There is work at the level of ideas, then these are networked up into the organisation (managing upwards) . . .the organisation sometimes gets in the way

The structure has to be there because of line management etc. , but, de facto, the Health Authority tries to work without Chinese walls.

In practice a range of interrelationships between public health and the health authority as a whole were found in health authorities. These can be seen as a spectrum of relationships:

[46] Department of Health (1994) *Public Health in England: Roles and responsibilities of the NHS and others.*

Public health priorities synonymous with → Health Authority	Public health is increasingly → influencing HA	Not all public health priorities are in → strategy	Public health does not drive the HA agenda

Public health priorities are synonymous with the Health Authority's priorities.
In many case study authorities, public health is explicitly the focus of the health authority. Respondents, both DsPH and Chief Executives alike, reported that public health had a strong role or was the core business of the health authority:

a public health philosophy exudes throughout the Health Authority . . .public health priorities are Health Authority priorities [Chief Executive]

The Health Authority thinks that public health is its core business, and therefore its priorities should be determined by public health . . . public health priorities do drive the Health Authority - we're lucky here in [name of Health Authority] [DPH]

These [public health] strategies very much determine the direction of the Health Authority. Also the major service strategies - for mental health, acute services etc. are all grounded in public health analysis and written from a public health perspective [DPH]

The Health Authority agenda is heavily shaped by the values of public health - for example our strong agenda on variations in health status and access to healthcare [Chief Executive].

Some noted, however, that influencing priorities is not always the same as getting them implemented. One DPH noted that though public health determined the policies, getting them into practice was more of a challenge. Similarly another DPH said that though there was not really a problem getting issues onto the agenda, there were some things that were difficult to implement.

Public health priorities are increasingly influencing the health authority agenda
In some of the other health authorities respondents reported a perceptible shift in the position of public health in the health authority. For instance one public health specialist said that over the last two years they had seen the public health function have increasingly more influence.

Not all public health priorities are in the health authority strategy
Some respondents reported that public health might still have some priorities that were not taken on fully in the health authority strategy, or that not all key people in the health authority were "on board" with them. These observations were made both in those health authorities where public health was largely driving the health authority agenda and in those where it was still moving towards this position.

In one health authority, both the DPH and an Assistant Director noted that ethnicity and health issues had been hard to get onto the agenda, though this is now becoming established as a priority and the Chairman had recently taken it on as an issue.

Where some public health priorities were not on the agenda, this was often attributed to the dominance of central priorities over local priorities:

Local issues are not yet on the agenda, though there is some good stuff being done. There is always a battle between what comes down from on high and what needs to be done locally. The former always wins [Associate Director Health Promotion].

In one health authority, the Chief Executive said that some of public health's hopes and aspirations are not given the prominence they wish, due to other priorities. A public health specialist confirmed this and noted that one such priority was hospital waiting lists.

Public health does not drive the health authority agenda
In one of the sites it was largely acknowledged that public health priorities did not yet drive the health authority agenda. It was noted, rather, that public health often had to fit into the health authority agenda. It is worth noting that the DPH was very new here and public health had been through a very unstable period in the recent past.

Public health does not drive the agenda of the Health Authority. Public health tends to respond to issues as they come up. In future we will try to change this [DPH]

Our work tends to have to fit into "boxes", for example the community development work is part of the Coronary Heart Disease programme [Public health specialist].

Other information gained during the course of the Project suggests that this position is not uncommon around the country. Our research necessarily took us to case study sites where we knew we would find examples of multi-disciplinary working, and, therefore, it was more likely that there would be a strong public health function driving the health authority than is typically the case. A recent report looking at public health work in some London health authorities observed that the "poor credibility of needs assessment work", "the dominance of the finance function in contracting" and the "often underdeveloped organisational link with the public health department" meant that local needs assessment had a relatively weak link to commissioning and investment decisions[47].

Factors which influence how these relationships have developed

Short termism of health authority agenda compared to public health agenda
As noted above, when health priorities were squeezed off the agenda it was usually attributed to the dominance of service issues perceived as more urgent, for instance keeping down waiting lists.

I do not think this Health Authority is driven by a burning mission to improve public health. We are also concerned to keep health services going, with good coverage and

[47] London Health Economics Consortium and SDC Consulting (1996) *Local Health and the Vocal Community: A review of developing practice in community based health needs assessment.* Commissioned and published by the Primary Care Support Force.

good quality. The Health Authority is more concerned with services than health gain. This is beginning to lead to some differences of emphasis [DPH]

There are also potential tensions in that the Director of Finance is necessarily working to a short term, two or three year timetable, whilst public health has a more long term perspective [Director of Finance].

These tensions can be creative as well as obstructive:

The Finance Directorate will challenge the Health Policy Directorate if they think that they are trying to implement something which will not work. So you need to support each other across the Health Authority, but the ability to challenge one another is also needed [Chief Executive].

The role of Finance

A large number of respondents referred to the Director of Finance or the Finance Department as the key to ensuring the whole health authority were "on board" with health priorities. It seemed that when they could demonstrate that the Director of Finance was in tune with public health priorities this was an indication that health authorities were working truly corporately to a public health agenda. Conversely, when there were dissenters within the health authority from the public health perspective, these were most commonly found in the Finance Directorate.

The Director of Finance sees himself as an investor in health gain, not just about accountancy concerned with financial control. He takes a more strategic approach [DPH]

Public health priorities are the Health Authority strategy. For example, the Assistant Director of Finance did the work on equity for this strategy [DPH]

Value for money means more health return for investment, not what savings can be made, and not just what funds are spent where [Chief Executive].

Elsewhere it was noted that finance staff had a key role to play in health strategy, but perhaps some in the Finance Department were not as focused on *health* as other parts of the Health Authority.

The role of non-executive members

A DPH in one health authority and the Chief Executive in another noted the particular importance of involving Health Authority non-executive members in public health issues in order to achieve corporacy around health priorities.

The role of individual personalities and personal attributes

The following answers were typical as part of the response to a question about the reasons for the existing relationship between public health and the health authority:

Personalities (Chief Executive, Director of Finance and DPH) and abilities [Assistant Director]

Personalities come into it. The previous Chief Executive who recruited me was very committed to public health - the present Chief Executive is equally supportive [DPH]

DPH and Chief Executive worked hard on [the relationship]. The Chief Executive was exposed to public health in the past [DPH].

The position of public health medicine in relation to public health as a whole
A key finding of the research was that the dominance of public health medicine within the public health function as a whole appears to impede the development of health authorities as public health organisations in some cases:

The relationship has not always been good and needs to be improved. Public health has not always been as influential as it might in the Health Authority in the past. The public health department was seen by others in the Health Authority as an elite bunch of doctors, and though this is now a slightly out of date perspective there are still barriers to overcome [Assistant Director].

The extent to which public health works across all directorates
It was important that public health was seen to be everywhere in the organisation and to take the lead in some of the commissioning:

Public health has a strong role within contracting - this is different from in other areas where I know public health colleagues are excluded or marginalised. On all the negotiating teams we've had people from public health [DPH]

Here the degree of crossing between directorates is considerable. For example, public health people lead on contracting [Chief Executive].

Respondents from two different health authorities referred to a "matrix" model of working.

The extent to which public health is a high profile activity for the health authority
Some respondents suggested the status of public health in the health authority and the strong relationship between public health and health authority as a whole was due to the profile of public health beyond the health authority:

The public health department works very well and is recognised outside [the Health Authority]. It has a profile nationally [DPH]

I am definitely not just the DPH of the Health Authority, but also of the city. The DPH annual report is seen as the "social barometer" (of the city - as one local newspaper wrote) [DPH].

Factors facilitating and obstructing multi-disciplinary public health working

Almost all our respondents had strong views on this issue. Many of the points that are discussed here were made by several people, though with varying degrees of emphasis, and the references that are made to sources are intended to give a flavour of the arguments, rather than to impute particular strength of feeling from those to whom reference is made.

It has been suggested[48] that the factors influencing collaborative working fall into three categories:

- those operating at the inter-personal level (such as personalities, personal commitment and enthusiasm, mutual respect, trust and flexibility);
- those operating at the organisational level (such as organisational structures, informal networks, organisational commitment, resources):
- those operating at the political level (national priorities, the effects of national and local policies).

The material that follows is grouped under a number of headings which reflect these categories, though there is a degree of inevitable overlap between some of them. No attempt has been made to separate factors into those which facilitate and those which obstruct multi-disciplinary public health, though the meaning is clear from the context.

Hierarchies and tribalism

The breakdown of unnecessary professional hierarchies and the culture of tribalism within organisations was seen by many as essential to improving multi-disciplinary public health.

Professional hierarchies were seen as reflecting the long-standing dominance of the medical profession within the NHS, in terms of their ultimate control over policy making, resource allocation, problem definition and the organisation of work.[49] While there have been changes as a result of the rise of managerialism, the introduction of internal market mechanisms and the increasing legitimacy of multi-disciplinary working, it is not clear from our case studies to what extent there has been any fundamental shift away from medical dominance. At the heart of the issue, there are often power differentials that may undermine multi-disciplinary work. The culture of tribalism, which was referred to throughout the workshop and by a number of respondents, generally referred to rigid and unnecessary boundaries between organisational departments, and between separate organisations, for example, health and social care agencies. This may reflect what Leathard[50] refers to as "professional baggage".

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[48] Davies J., Dooris M., Russell J. and Petterson G. (1993) *Healthy Alliances: a study of inter-agency collaboration in health promotion* Jocelyn Chamberlain Unit for Health Promotion and Disease Prevention, Department of Public Health Sciences, St George's Medical School.

[49] Wilding, P. (1982) *Professional power and social welfare* Routledge.

[50] Leathard A (ed.) (1993) *Going Inter-Professional? Working together for Health and Welfare.* Routledge

One respondent advocated flexibility and felt that old modes of working in the NHS meant territorialism and a lack of information flowing between departments. In a community trust, an organisational culture of nurses being involved in practice profiling and bringing the whole team on board was viewed as a helpful contribution. Several Chief Executives commended the mutual respect of various skills, and in similar vein, a public health specialist praised collaborative work which recognised everyone's input.

Some felt that identifying and explicitly recognising the skills needed and valuing these skills, whatever route people have come through, was important. A DPH referred to professional indoctrination, and pointed out that this is not necessarily about personal differences, but people come from different positions. She observed that one needed to work through this and then it could be productive. All these comments made it clear that whatever people's professional background and place in the organisation, it had to be transcended to some extent if multi-disciplinary work in public health was to succeed.

Formal and informal structures

The structures within which people worked varied. It was often said or implied that waves of organisational change had been very challenging, and it had become necessary to work in spite of formal structures, as well as through them. Moreover, uncertainty about future structures was seen by some as unhelpful, even if possible political changes made some uncertainty inevitable. Where there had been stability, it had helped. A DPH summarised the benefits of cohesiveness and a stable group in public health, and felt that the benefits of a sustained strategic approach were becoming evident as a result.

As noted above informal structures were apparently as significant or more significant than formal structures. Two respondents who were involved in the Health Park in South Bristol described the need to look for partners to work with. This sometimes began on a relatively informal level, and became integrated into organisational structures.

There was no single model that seemed to be particularly helpful or unhelpful to multi-disciplinary public health working. Whereas, some commended a "tight core" in the public health department, others felt that having a multi-disciplinary range of people in the public health department which can then act as a catalyst was a better way forward. The particular structure that was favoured seemed less significant than the convictions of those who were in it. Also, clarity of role and responsibility mattered. One respondent made the case for being clear where boundaries overlap and the extent of overlap and said that this understanding needs to be jointly developed.

Structures outside the health authority were also significant. An Assistant Director highlighted the importance of having a good voluntary sector infrastructure. Also, structural issues in local government were important, not least because of the recent changes where unitary authorities had been formed.

Communications

Given the range of structures within which people worked, and the numbers of people and disciplines that might be involved in public health, communication was seen as important, with no dissenters to that view. Some communications networks, such as the Four Counties Public Health Network (Oxfordshire, Buckinghamshire, Berkshire and Northamptonshire) were of proven value. There were, however, varied views on the relative merits of electronic or personal communication. Some based their hopes in technology, while one respondent ruefully observed

People will e-mail each other or ring, but won't walk up the stairs [to another directorate/section].

Leadership and commitment from the top

While hierarchy, *per se,* was seen as obstructive, leadership from a committed individual was seen as very positive. Leadership on effective multi-disciplinary public health could and did come from a variety of sources, be it the Chief Executive, DPH, or elsewhere. The active support of a committed Chief Executive seemed to be very important, though in some instances support was more hands-on than others. It was striking how frequently the leadership came from a senior woman in the organisation, and some of the women noted this themselves. In some of the organisations that we looked at, gender was possibly more consistent than job title as an indicator of where support for multi-disciplinary public health came from in the organisations that we studied, though some honourable exceptions to this generalisation could most certainly be found.

A Director of Public Health Nursing said:

Leadership is important. Things start with individuals. Then you try and get it embedded into the culture.

A Health Authority Chief Executive stated:

[Multi-disciplinary public health] grows out of clarity of purpose and clear work programmes in each Directorate. There needs to be a lead responsibility and a co-ordinated input.

The Chief Executive's role in supporting the development of a major new proposal at crucial stages was seen as very important by staff, (as illustrated by case study 11).

One Chief Executive was unequivocal:

It all comes from the top [the Chair and Chief Executive].

Likewise, another Chief Executive argued that having a clear commitment to a multi-disciplinary approach facilitates its effectiveness:

You need this push from the Chief Executive, but also from others such as the Finance Directorate.

In discussing leadership, we asked most respondents whether they felt that the public health function needed to be led by a doctor. Predictably there was a range of views, as the following comments indicate:

I am not uncomfortable with it being a doctor. It helps with credibility and skills [Chief Executive]

Yes. Much of our work is with doctors. There are issues of credibility, and also the experience of being a doctor: "We don't swallow the bullshit they [doctors] give us". The experience of being a doctor alters our attitudes; it is not just a matter of clinical skills [DPH]

No. The leader does not need to be a doctor. Here, the Directorate is led by a doctor, but that is down to personal attributes rather than discipline/qualification [Chief Executive]

Theoretically no, in practice, yes. The profession would rebel [Chief Executive]

You would not need to be a doctor to be DPH, but you would have to give status to a clinical person to do the clinical interface [DPH].

The point was also made that the public expected statements about the public health to have the credibility of a doctor's opinion behind it.

Personalities, individual relationships and teamworking

The words people used varied, but the message was consistent: whatever else was going on, personality mattered. Possibly because informal networks were significant, human relationships mattered very much in ensuring multi-disciplinary public health.

One DPH spoke of the implications of the significance of personal 'chemistry' and felt that recruitment processes had to give opportunities for people to interact to see if they could work together. A Chief Executive also felt that multi-disciplinary public health was "down to individuals".

Trust between individuals was important. The GPs on the Oxfordshire public health learning set agreed with that, and observed that it helped to know the people in the public health department. A harmonious and positive relationship with the previous FHSA, and the continuity of that relationship, vested in the public health specialist was helpful. A Chief Executive stressed the importance of accepting that the whole is greater than the parts and felt that corporate attitudes were important, more than structures. He also mentioned "personality" and leadership and charisma as important. His colleague, the DPH also took the view that people's agendas, styles, inability to share, inability to see the broader picture, to co-operate would obstruct multi-disciplinary working.

A senior manager spoke of the need to be part of a "public health family" Her Chief Executive spoke of the need to be a team player. An Assistant Director in that Health Authority favoured judging performance on team objectives rather than personal contributions only.

A Chief Executive said that those working in public health should be willing to share skills and the "name" of public health. Her DPH colleague felt that effective multi-disciplinary public health working occurred where there was recognition from the Chief Executive that public health is not a threat, but a contribution.

While most people might, in reality, aspire to, rather than achieve this sublime mixture of human relationship skills, combining individual responsibility with teamwork and sharing, it is clear that the human dimension of multi-disciplinary work is very important. While such relationships can thrive in a variety of contexts, stability, trust, respect and sharing are all essential to effective work, and at the very least, structures that do not undermine such attributes are essential.

Education, training and career development opportunities

Respondents frequently asserted that those who worked in public health in non-medical disciplines had much poorer opportunities for training and consequent career development.

The significance of training and career development opportunities was also a recurring theme at the June workshop, and our findings reflected those reported in the recent report on the training and career development needs of public health professionals.[51] This report noted that:

- the current situation with regard to the career progression of non-medical staff is chaotic and ad hoc
- the inequitable system between medical and non-medical personnel in public health acted as a barrier to joint working
- full membership of the Faculty of Public Health Medicine is still not open to non-medical staff
- training opportunities for non-medical public health staff are also ad hoc, but are improving, with several cited examples of good practice.

A Director of Public Health Nursing felt that more nurses should be encouraged to take on roles like her own. She felt that open access to Masters degree courses in Public Health would widen multi-disciplinary public health, and not just for nurses.

The nature of training was also an issue. As one DPH explained, public health training trains one for an *"arms-length, back room"* approach, rather than the one that he uses. His Chief Executive also queried the nature of public health training, suspecting it of leaning towards the technical and scientific approach.

The need for public health doctors' training to include management skills was also raised by some respondents, and this was also an issue that was discussed at the June workshop.

A Chief Executive said that Masters degree courses in public health should be accessed by people with different backgrounds, as this reflects the necessity to have different

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[51] Somervaille Dr L and Griffiths Prof. R. (1995) *The training and career development needs of public health professionals. Report of postal survey and discussion workshops.* Institute of Public and Environmental Health, University of Birmingham.

skills involved. A doctor may not have these skills and needs others to complement his/her personal skills and knowledge. One public health specialist advocated some common training for different disciplines to learn a bit about each others' expertise and skills.

One respondent described the problems that ensue from having a clear career structure for doctors in which they are encouraged and facilitated at every stage, whilst others do not get the same treatment - a situation which leads to resentment from those who do not have a clear career structure. It was noted that other public health specialists frequently see doctors come into the public health department, work on a small project (on which others often do the work with little thanks and respect) and then the doctor becomes a Consultant. Information staff within the department, often on very low grades, are training doctors on the computers so that the doctors can do their projects, but they do not progress their own careers while helping the doctors. Registrars in public health must be committed to multi-disciplinary working and not just focused on their own work and getting their qualifications.

Directors of Public Health, amongst others, referred to different pay scales and career pathways. They felt that this was not easy to deal with and tried to get people upgraded sometimes to even things out, but it was not easy. However, one DPH added an interesting view that if there were a rigid public health career progression this might stifle unique skills.

Some respondents highlighted the problems of accessing training monies for public health specialists without medical qualifications, and this was also discussed at the workshop. This is an obstructing feature when trying to support the professional development of public health specialists.

Status of non-medically qualified people working in public health

The issue of status is closely linked to issues of training and career opportunity, and it was keenly felt by some respondents. Again, our findings reinforce the detailed report by Somervaille and Griffiths[52], and we do not attempt to repeat that material here. One Director of Public Health was eloquent on this matter:

Historically, health promotion and other disciplines in public health defined themselves in opposition to medicine. The trick is to avoid defining yourself by opposition to medicine. There are two ways to define identity. If identity is defined as distinctiveness to 'the other', then the relationship between two groups can either be opposing, or 'I feel fully part of my professional identity, but only part of the world, and others are equally important and valid'. It is this latter view that means that we can work towards making the whole more than the sum of the parts. To take this position individuals need confidence and to recognise the value of the other. Us and themism is the most destructive element of public health, as it perhaps is of human life!. In [name of Health Authority] we are trying to work towards putting this theory into practice, in an evolutionary way. I respect the non-medical disciplines I work with as much as I do the medical and they respect me.

[52] Somervaille Dr L and Griffiths Prof. R. *op cit.*

Several respondents stated that there is more to public health than public health medicine, e.g. expertise in social science, human geography and economics.

A senior manager who was not medically qualified said that staff without medical qualifications should be in senior positions in the department - having a hierarchy whereby the DPH is at the top with only medical doctors reporting to them lowers the status of those with other skills and disciplines reporting to those doctors.

A broad view of what constitutes good information and evidence in public health
Status is not an independent variable. Those in public health who are not public health doctors will only thrive where a broad view is taken on what public health actually is, and what evidence counts as acceptable.

A manager of a Public Health Resource Centre thought that doctors in public health tend to have a broader outlook than clinical doctors. Nevertheless, he suggested, doctors trained in classical public health still have an over-reliance on quantitative work and can be dismissive of qualitative work. A public health specialist warned that having a purely medical view/ perspective would greatly undervalue local community development projects. Her DPH colleague did not approve of groups trying to "own" public health by claiming that their own definition should be the only one to count.

The relationship of public health to the health authority as a whole
There was a very high level of awareness of the need to retain independence while having a maximum impact on corporate health authority business. A DPH said that a multi-disciplinary department needs to be skilled managerially and he, and others, said that it must subsume its agenda to corporate aims:

You have to take account of the constraints [DPH]

As Chief Executive, I don't want public health to have clean hands - they've got to get stuck in with me [Chief Executive].

One DPH argued for a strong role for public health within contracting:

On all the negotiating teams we've had people from public health. Although contracting is co-ordinated by the Director of Commissioning, the multi-disciplinary contribution is enormous [DPH].

In one Health Authority, the Chief Executive valued the DPH for her willingness to be so fully a part of the executive team, and he felt that public health took a lead role on many issues. Equally, the Director of Public Health was clear that DsPH had a right to express views that are not comfortable for the Health Authority to hear.

Another Chief Executive perhaps spoke for many when she described the role of the Chief Executive as follows:

As Chief Executive, I drive the vehicle (sometimes in adverse road conditions) and I say help me navigate! [DPH].

If that analogy holds good for others, the corporate agenda is driven by a Chief Executive, but he or she would become hopelessly lost if public health was not able to give firm, reliable and assertive advice on direction of health policy and strategy.

Resource constraints - time and money

While more time and greater financial resources may not, in themselves, solve problems, resource constraints were generally viewed as obstructive features. There is evidence in recent literature that there is a difference in the extent of innovation between health authorities that are experiencing growth as a result of changes to weighted capitation, and those that are experiencing losses. As Watt and Freemantle[53] explain:

Purchasing authorities which experienced growth were often using the increased funds innovatively, and were attempting to purchase for health gain... Where there was no new money, ... ideas on how to improve the health of the local population were often subsumed to the overall aim of containing costs.... In the authorities experiencing little or no growth, the role of departments of public health in facilitating change and helping to obtain improvements was often limited...

In one community trust, it was felt that pressures on time, practice pressures and the ever increasing pressure on primary health care is reducing the amount of time available to spend on the process of building multi-disciplinary relationships.

Other respondents agreed that lack of time and money were constraining factors.

In one health authority the Director of Public Health explained that the public health department does not now have geographers or social scientists. This partly reflects the need to reduce management costs, although it was recognised that within available resources, there are choices to be made.

Another DPH made a similar point about management costs, and explained that they bought in skills that they did not have, such as a health economist, when needed. This was seen as not a wholly bad way to approach things.

Finally, there is a wage differential between public health doctors and other public health specialists. This differential probably impeded effective multi-disciplinary work, not least because it signifies status differentials.

Pragmatism and political imperatives

People working in public health tend to have a keen awareness of the constant compromises that are made between idealism and pragmatism. Nevertheless, they often felt that a public health approach could be unduly blown off course by the urgent demands of the day, or by national imperatives.

One Assistant Director felt that national policies developed in isolation, and which did not recognise the need to integrate policies across departments, were very unhelpful.

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[53] Watt I and Freemantle N. (1994) "Purchasing and Public Health: the State of the Union" *Journal of Management in Medicine*, 8,1 pp6-11.

She also referred to the "short termism" of policies and the monitoring techniques which do not take into account the nature of public health and the successes which cannot be quantifiably measured.

Several referred to the need to reconcile local priorities and national imperatives, and ensure that the national imperatives do not dominate. Some recognised that public health strategies do not determine the overall direction of the health authority as much as they should. Health service delivery mechanisms still dominate. Health gain and outcomes should be main focus, but this was still not entirely so.

In the many discussions about the impact of the NHS medium term priorities, there was a sense of relief that these were now fewer and broad enough to accommodate much of what health authorities would determine as their own priorities. One DPH acknowledged that the Regional Office had consulted on the medium term priorities, and were asking how they can make them fit in with what the Health Authority was trying to do. However:

The medium term priorities are for the political agenda, but they all go in different directions, e.g. ITU, waiting times, Cancer (Calman)...We are spiralling out of financial control, with a £1m+ overspend on mental health ECRs. How does having mental health as a medium term priority help with that? [DPH].

And as a Chief Executive acknowledged: "*We have to tick the boxes*".

There was also a fairly high level of cynicism about rhetoric. The primary care-led NHS was variously described in strong language using words such as *"gibberish"* and *"bullshit"*, though respondents hastened to add that their judgements related to the cynical use of rhetoric, rather than to a primary care-led NHS itself!

Perhaps the most frequent comment was that multi-disciplinary public health tended to result in a focus on health and not just health care, while central priorities can pull in the opposite direction, towards acute hospital issues in particular.

Summary

There was a high level of consensus on the factors that facilitated and obstructed effective multi-disciplinary public health. Many of these factors, such as good communications, clarity of purpose and mutual respect, would be regarded as essential in any working situation, but their importance is underlined precisely because of the multi-disciplinary dimension. It is also striking how much informal structures and personal relationships mattered to successful multi-disciplinary public health, and there is clearly room for further examination of how to support and enable such relationships to thrive.

8. IMPLICATIONS FOR THE FUTURE OF MULTI-DISCIPLINARY PUBLIC HEALTH

Throughout the report, the main findings of the project have been described in each section, and the Executive Summary brings together the main points of the report as a whole. This section explores some of the implications for the future of multi-disciplinary public health, in the light of the findings of the project.

Making the case for multi-disciplinary work in public health

It has been implicit in this project that multi-disciplinary work is likely to be of positive benefit to public health, and in section 6, the added value of a multi-disciplinary approach to public health was explored. However, although respondents suggested and implied many ways in which multi-disciplinary work was valuable, we were struck by three interesting contexts to their comments.

Firstly, while multi-disciplinary work was, indeed, widely accepted as "a good thing", the belief in it sometimes had the feel of a mantra, rather than being based in evidence on what works best in public health. While this report goes some way to indicate a number of apparent benefits of a multi-disciplinary approach, the way remains open for a more detailed investigation of precisely when and how multi-disciplinary working can lead to the greatest benefits. If multi-disciplinary work in public health can be shown to add value, a more consistent and widespread adoption of such an approach could be expected and monitored more effectively.

Secondly, although respondents provided ample evidence of the perceived benefits of multi-disciplinary work when asked to do so, it was comparatively rare to study a site where there was a clear, shared definition of multi-disciplinary. As has been discussed earlier, the proliferation of definitions was striking. Furthermore, the project team frequently felt that working definitions had often been swiftly constructed in order to allow a meaningful interview, rather than reflecting a considered, agency-wide definition that was in current use and shared with colleagues.

Thirdly - and this point is linked to the previous point - it was noted that many respondents were interested to discuss multi-disciplinary public health working, but multi-disciplinary working would not have been a starting point in terms of their own current interests and preoccupations. There was, however, considerable interest in identifying what skills are needed in order to purchase for health gain. In other words, the starting point would have been different for some people, although the identification of a range of skills might well lead back to multi-disciplinary work as a focus of interest.

"Multi-disciplinary-friendly" structures

It was plain that even where there was a wholehearted commitment to a multi-disciplinary approach, structures within health authorities, and inter-agency structural

mechanisms rarely enabled multi-disciplinary work to be as fruitful as it might. As we have seen, an approach to formal structures that might be termed creative anarchy sometimes prevailed. The project team became ever more convinced as the project developed, that a major key to progress was the development of a range of supportive mechanisms to enable the use of less formal structures.

Training and professional development

The removal of training and career development obstacles is of paramount importance to multi-disciplinary public health, and defensive attitudes from those who may fear for the future of public health medicine as a profession would run counter to the many benefits of a broader approach to public health within the NHS.

The importance of team working, within organisations and across organisational boundaries, was recognised in *A service with ambitions* which pledges further work to encourage multi-professional working in the NHS.[54] A reconsideration of the deployment of NHS Education and training budgets is also promised. This will benefit the development of multi-disciplinary public health if it addresses the issue of funding for training and professional development of non medically trained public health specialists.

Public health at the cross-roads

The timing of this project was particularly interesting, since public health itself is in a somewhat paradoxical position. On the one hand, public health is seen as fundamental to the business of new health authorities. More than one of our respondents had no hesitation in describing their health authority as a public health organisation, or striving to be one. On the other hand, cost pressures also pose severe limitations on the extent to which public health can be the driving force. This limitation manifests itself both in terms of the driving down of management costs, which limits the range and number of disciplines that can play a continuing part in the public health function in health authorities. It also manifests itself in the conflicting pressures that a health authority may experience. Its budget is pulled one way by medium and long term public health considerations and the desire to purchase for health gain, and in another direction by the shorter term needs to purchase urgent health care.

Public health is also having a period of introspection wherein many of its specialists, from all disciplines, are trying to clarify their responsibilities and their loyalties. The great majority of respondents in this project were clear that public health can be most effective where it is fully integrated into the corporate business of health authorities. However, the need to be independent and the right to give possibly unpopular advice to the health authority are also jealously guarded.

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[54] Secretary of State for Health (1996) *The National Health Service - A service with ambitions* Cm 3425 HMSO.

The future of public health

There is considerable interest in the question of where public health should be located. Some respondents made a strong case for public health remaining at the centre of the health authority, and involved in an integrated way with the corporate agenda of the whole health authority. Others made the case for the public health function to be led by local government, rather than the NHS.

Others referred to the need for greater partnership between the NHS and local government on the broad public health function. The role of universities and public health consultancies was also important, and close and continuing relationships were developing in a number of places. Public Health Resource Centres also offer an interesting way forward.

One Director of Public Health felt that future models for public health organisations will probably be more diverse - a mixture of research institutes, consultancies, employed staff, and concluded:

Public health has a key role to play - whether it remains in the health authority or returns to local authority. It is more likely to remain in the health authority, however, as purchasing is probably the best thing that ever happened to public health. Also, Health of the Nation initiatives etc. all bolster public health. There is still much to be done and we should be optimistic about the future [DPH].

Some would also argue that providers also have a key role in public health. It was suggested that work in alliance between health authorities and providers helps to get more focus in hospitals on issues other than Patient's Charter and efficiency. Having public health focused or based in the provider unit also gives opportunity for "insider intelligence".

Changes in attitude

Finally, the way forward for multi-disciplinary public health will inevitably require shifts in attitude and a more open-minded approach to power sharing within health authorities and between professions. Despite widespread support, at least at the level of rhetoric for multi-disciplinary public health, the dominance of medicine in the professional hierarchy is still strong. As a profession, public health medicine expresses some ambivalence towards greater multi-disciplinary working, and may feel threatened by it. On the one hand, it embraces it and values the multi-disciplinary contribution highly. On the other hand, as Kisely and Jones[55] remark:

The Acheson Report advised that there should be 15.8 consultants per million head of population. Whilst the government supported a massive increase in training to meet this target, health authorities have not undertaken the expansion in consultant posts

[55] Kisley, S. and Jones, J. (1995) "A hive of activity: the future of public health" *Public Health* 109(4) pp227-233.

necessary. In addition, the problem has been compounded by a move towards multi-disciplinary team-based working within public health. As a consequence, it is possible that a manpower crisis is facing a cohort of public health medicine doctors in training for whom there appears to be little likelihood of consultant posts in the near future [Our emphasis].

A rational way forward must be based on a needs-led approach, and multi-disciplinary working needs to be able to demonstrate that it adds value to a mono-disciplinary approach. Ultimately, neither the needs of public health medicine doctors nor the needs of other public health specialists should determine the way forward. It is the maintenance and development of the health of the public that is most important of all.

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Appendix one

List of participants at workshop on multi-disciplinary public health, 20 June 1996

Jacqui Barker	Bromley Health
Kate Billingham	Director of Public Health Nursing, Sheffield HA
Tony Byrne	Royal Society of Health
Dr Mark Charny	Public Health Division, NHS Executive
Carolyn Clark,	Asst. Dir. Community Involvement, Brent and Harrow HA
Yvonne Cornish	Lecturer. SE Inst. of Public Health
Angela Coulter	Director, King's Fund Development Centre
Dr Lindsey Davies	Director of Public Health, NHS Executive, Trent RO
Rosemary Dando	Regional Director of Nursing, NHS Executive, Trent RO
Alison Frater	Public Health Specialist, Hertfordshire HA
Lance Gardner	Total Purchasing Project Manager, Castlefields, Runcorn
Dr Mike Gill	Director of Health Policy and Public Health, Brent and Harrow HA
Shirley Goodwin	Associate Director of Primary and Community Health, Hillingdon HA
Jenny Griffiths	NHS Executive, North Thames RO
Ursula Harries	Senior Research Fellow, Public Health Research centre, Salford
Julie Harvey	Public Health Strategist, East London and City HA
Matthew Hickman	Epidemiologist, Brent and Harrow HA
Nikki Joule	Project Researcher, King's Fund
Dr Zarrina Kurtz	Consultant in Public Health and Health Policy
Ros Levenson	Project Manager and Researcher, King's Fund
Alison McCallum	Consultant in Public Health, Enfield and Haringey HA/ Snr. Lecturer Royal Free Hospital School of Medicine
Amy Nicholas	NHS Executive, Public Health Division
Aislinn O'Dwyer	Specialist in Public Health and Primary Care, NHS Executive NWRO
Donald Reid	Association for Public Health
Jill Russell	Project Researcher, King's Fund
Alex Scott-Samuel	Dept. of Public Health, University of Liverpool
Lillian Somervaille	Public Health Dept, University of Birmingham
Dr David St George	Consultant, Royal Free NHS Trust
Vicki Taylor	Health of the Nation Manager, Camden and Islington HA
Mary Tompkins	Pharmacist, NE Essex HA
Angela Young	Public Health Resource Centre Manger, Manchester HA

Methodology

The project brief indicated a case-study approach to reviewing good practice in multi-disciplinary public health working. A preliminary task for the research team was to clarify what constituted 'a case' for study. A decision was taken to adopt a two-tiered approach to the identification of cases. Firstly, cases comprised health authorities - at this level we looked broadly at the relationship between public health and purchasing to examine the context within which multi-disciplinary working occurred. Within each health authority, we then identified cases of specific initiatives that illustrated multi-disciplinary working.

Initially, three health authorities were selected to pilot this approach and the draft interview schedule (see appendix 3). These authorities were selected from a list of geographical areas identified by **Dr** Lindsey Davies (Director of Public Health, Trent Regional Office) for the research team of where good multi-disciplinary working relationships exist (although interestingly, one of the areas did not perceive themselves as falling into such a category).

Following pilot work in the initial three sites, and drawing upon information obtained at the Project workshop, a full list of criteria for the selection of case-studies was agreed:

- Geographical spread - there should be a spread across all 8 NHS Regions.
- Range of settings - in addition to health authorities, there should be some coverage of a provider setting and a GP fundholder.
- Range of health issues - including Health of the Nation priorities and 'traditional' public health issues.
- Range of types of multi-disciplinary working - including inter-sectoral, inter-professional, healthy alliances, etc.
- Range of organisational structures - including matrix organisations, locality based teams etc.

In addition, all case-studies would be characterised by:

- Prima facie indication of commissioning influenced by public health
- Prima facie indication of multi-disciplinary working
- Relevance of NHS medium term priorities
- Availability of interviewees during August/September 1996
- Not previously published in detail elsewhere

On the basis of these criteria, a further 8 areas were selected for case-study investigation. In total, therefore, 11 case study sites were chosen:

Avon Health Authority
Bromley Health Authority
Brent and Harrow Health Authority
Enfield & Haringey Total Purchasing Project (TCP)

Hillingdon Health Authority
Newcastle and North Tyneside Health Authority
North Downs Community Health Trust
North West Region Public Health Research & Resource Centres
Oxfordshire Health Authority
Sheffield Health Authority
North Staffordshire Health Authority

In the majority (7) of the case study areas , the research team began by conducting interviews with the Chief Executive and Director of Public Health, using an interview schedule which respondents were sent in advance (see appendix 4). From these interviews other relevant people were identified for interview and initiatives to explore in more detail. In the remaining four areas different approaches were adopted to suit the local circumstances - in one area a member of the research team spent a day 'shadowing' a senior health authority purchaser; in two areas group discussions were organised (with GPs and public health specialists in one, and clinical team members of a community trust in the other), and in the North West Region telephone interviews were conducted with managers of the Resource Centres.

Given the time frame of the project (which allowed under 3 months for the fieldwork, and spanned the summer holiday period) and the limited research resources available, it was impossible for the project team to undertake more than a brief investigation of issues and initiatives at each of the case study sites. It is clear that health authorities, provider units, and the many agencies with which they work, are complex organisations in complex relationships with each other, each with their specific characteristics contributing to why they are working in particular ways. In-depth case study work to do justice to this complexity would clearly have required a different level of research investigation.

In total, the research team carried out 26 face to face interviews (two involving two respondents), 6 telephone interviews, two group discussions involving 5-7 people, and observation at two health authority meetings. A wide range of professional groups and public health/purchasing roles were covered by this process (health authority Chief Executives; Directors of Public Health, health promotion, finance, health policy, primary care, research & development, nursing, social scientists, town planning, etc.). In each area a range of documentary material was also collected for analysis (annual reports, purchasing plans, health strategy documents and relevant articles). All interview data collected by the research team was written up and agreed with respondents prior to inclusion in this report.

In general, there was a positive response from those invited to participate in the research process and respondents gave their time generously to the project. Several respondents made unsolicited comments concerning the usefulness of being prompted by the research to think about and discuss the key issues concerning multi-disciplinary public health working, and hinted that the research process itself could be a facilitator of change. In one area (which the NHS Executive had identified at the pilot stage as being a district where good multi-disciplinary working exists), the Chief Executive declined for his Health Authority to be involved in the project, commenting that with

reductions in staff, the Health Authority was forced to make some hard decisions about what it could and could not get involved in.

Data from primary sources was supplemented by some (but limited) literature sources. The project brief did not include a literature review, however, a search was undertaken for relevant material on the King's Fund library database, and other relevant material collected from colleagues and the NHS Executive. This material was used wherever possible to contextualise the case-study findings.

Appendix three

Multi-disciplinary public health
Questions/themes for pilot interviews

1. What are the public health priorities for [name of HA]?

2. How far do these public health strategies determine the overall direction of the HA?

3a. What other driving forces (in addition to public health concerns) influence the HA's commissioning?

3b. (prompt if necessary): How significant are the medium term priorities (as in the NHS Executive's Priorities and Planning Guidance for the NHS 1996-7) ?

4. How are the local public health priorities set? By whom?

5. What have been the notable achievements in the commissioning and purchasing agenda, involving multi-disciplinary public health?

6. What has changed in HA commissioning because of the public health priorities?

7. Does public health have any priorities that are not reflected in HA commissioning?

8. Who contributes to public health in your HA?
(HA employees? Who?)
(Non HA employees? Who?)

9. In the context of public health, what do you understand by multi-disciplinary work?

10. To what extent are multi disciplinary public health roles interchangeable/distinctive?

11. Describe the distinctive roles of different disciplines in [name of HA].

12. What facilitates effective multi disciplinary public health?

13. What obstructs effective multi disciplinary public health?

14. In a multi disciplinary public health team, does it need to be led by a doctor? Why? Why not?

Appendix four

Interview schedule for multi-disciplinary public health project

1. Who is involved in public health in [name of area]? Please supply an organisational chart and any other relevant material that may explain structures.

2. In the context of public health, how would you define multi-disciplinary work?

3. What do the various people involved in multi-disciplinary public health bring to it?

4. What are the public health priorities for [name of HA]?

5. How would you describe the relationship between public health and the Health Authority as a whole? For instance, how far do the public health priorities determine the overall direction of the Health Authority?

6. Why do you think that this relationship between public health and the Health Authority as a whole has developed in this way?

7. What other forces (in addition to public health concerns) influence the HA's commissioning?

8. How significant are the medium term priorities (as in the NHS Executive's Priorities and Planning Guidance for the NHS 1997/8?)

9. What have been the notable achievements in the commissioning and purchasing agenda, involving multi-disciplinary public health? For instance, what has changed in Health Authority commissioning because of public health priorities? Can you give some examples?

10. Does public health have any priorities that are not reflected in Health Authority commissioning?

11. What facilitates effective multi-disciplinary public health?

12. What obstructs effective multi-disciplinary public health?

13. Should the public health function be led by a doctor? Why? Why not?

14. What has been the impact of the merger of DHAs and FHSAs on the development of multi-disciplinary public health?

15. How do you see the future of public health?