

**Public Health Responsibility and Capability
in the North West Region**

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ISBN 1-902001-21-1

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Appendix 1 Questionnaire

Acknowledgements

We would like to thank all the busy staff from NHS Executive North West, NHS Trusts, Government Office North West, Primary Care Groups, Health Authorities, Local Authorities and Councils for Voluntary Service who took part in this survey and filled in the questionnaire. We would like to thank Professor John Ashton for his support and encouragement; Jan Hutchinson for her assistance in developing this piece of work; Dominic Harrison and Mary Kilfoyle for comments on the manuscript.

Public Health Responsibility and Capability in the North West Region

1 Executive Summary

1.1 Introduction

A wide variety of social and public policies as well as behaviours relating to lifestyle determine the public's health through their influence on the way people live and engage with each other.¹ Public health practice seeks to understand and influence the politics that determine health and apply scientific knowledge to the organised efforts employed to promote and protect the public's health.

Increasingly public health is seen as everyone's business and through legislation and directives in White Papers, Government is encouraging organisations, communities and individuals to work in partnership to tackle important cross-cutting public health issues. However, a basic premise for partnership working is clear communication and a good understanding of current responsibilities. This Government appears to understand the importance of public health to economic regeneration and well being and has put considerable resources into public health. The public health agenda is escalating and will be matched by an increasing demand for public health skills in the wider workforce.

This study was carried out to determine the comparative levels of responsibility for, and expertise in public health held by various organisations actively engaged in public health practice and to determine whether across organisations there is a good match of skills with responsibilities.

Senior staff from seven organisations (Health Authorities, Local Authorities, NHS Executive North West, Government Office North West, Primary Care Groups, NHS Trusts and Councils for Voluntary Service) actively involved in public health were asked to:

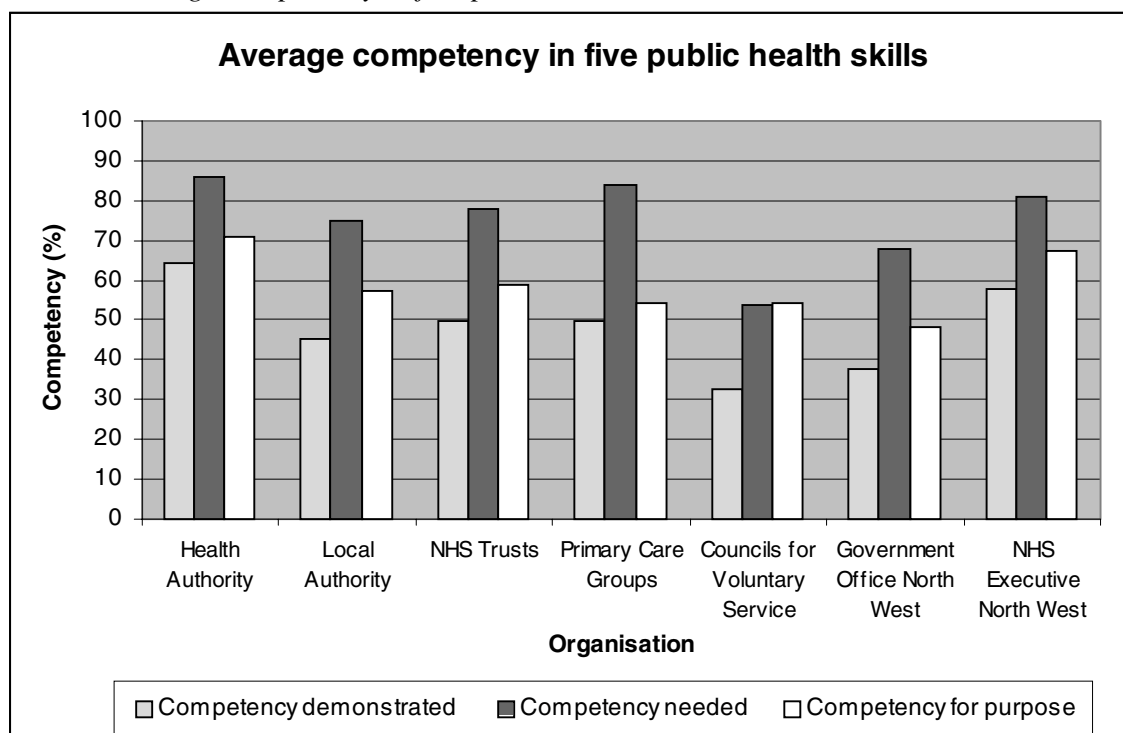
- Rate their own and each of the six other organisations for;
 - *Ability in five public health skills* - Individuals were asked to judge each organisation's existing level of competency and also to indicate each organisation's required level of competency to perform effectively at their appropriate level in each skill category.
 - Their *level of responsibility* in fifteen cross cutting areas of public health (e.g. tackling income inequality, promoting healthy lifestyles in schools).
- Identify whether or not they worked jointly with the other organisations in eight key areas of public health.

1.2 Findings

1.2.1 Skills

- Overall, Health Authorities were regarded as the most competent (average score 64%) and also the organisations that needed the highest level of competency across all five skills studied (average score 86%). (See Table 1) Thus Health Authorities demonstrated 71% of the competency needed, henceforth referred to as 'competency for purpose'. NHS Executive North West ranked second in both competency demonstrated (average 58%) and competency for purpose (average 67%). Local Authorities were thought to need a relatively high level (average 75%) but demonstrated a relatively low level (average 45%) of competency across all the skills measured, achieving an average of only 57% competency for purpose. Government Office North West and Councils for Voluntary Service were regarded as the organisations with lowest average levels of required (68% and 54% respectively) and currently demonstrated competency (38% and 33% respectively). Together with Primary Care Groups they were also thought to demonstrate the lowest levels of competency for purpose. Government Office North West was considered to possess 48% and both Councils for Voluntary Service and Primary Care Groups 54% competency for purpose across the five public health skills studied. Importantly, no organisation achieved the required level of competency for purpose in any of the public health skills examined. Respondents thought that Primary Care Groups should demonstrate a high level, (83%) but that they only demonstrated around half of the competency required in promoting health and well being. Local Authorities, Primary Care Groups and Government Office North West were perceived to have less than half the competency they needed to perform effectively.
- The need for public health skills throughout all organisations studied was demonstrated by the average level of competency required which ranged from a low of 54% for Councils for Voluntary Service to a high of 86% for Health Authorities. On this comparative scale Local Authorities were thought to require an average level of competency across all skills of 75%, Government Office North West of 68% and Primary Care Groups 84%. Breakdown for each organisation by individual skills are given in Tables 5 to 13.
- In general, staff rated the public health skills of the organisation where they worked higher than did respondents in other organisations (see Tables 6 to 14). This represents a mismatch in perception and a misunderstanding about each organisation's public health skills. Local Authority staff invariably thought that the Local Authorities had a higher level of competency than did respondents working in other organisations and this difference was statistically significant for 4 out of 5 skill areas. (See Tables 6, 8, 10, & 14). Overall, 'collaborating with other professions, groups and disciplines contributing to the health of the public' was the skill most commonly rated higher by the staff of the organisation than by respondents in other organisations. (See Table 14). For instance, Government Office North West own staff's rating was 78% compared to other respondents' rating of only 40% in this skill area.
- The reported high levels of competency required by all organisations studied demonstrate the perceived need for public health skills in all organisations.

Table 1 Average competency in five public health skills



1.2.2 Responsibilities

Overall Local Authorities and Government Office North West, the two organisations of local Government, were considered to have most responsibility for, and therefore most influence over, the wider determinants of health. (See Table 2) Local Authorities were thought to have most responsibility in eight of the fifteen public health areas measured (see Tables 15 to 44). However, Health Authorities had most responsibility in areas of health promotion relating to personal lifestyle and health care (see Tables 19, 21, 33 & 43).

Primary Care Groups were considered to have similar responsibilities to Health Authorities but at slightly lower levels. The exception to this was in the area of 'working with communities to improve health' (see Table 41,) where the highest level of responsibility was attributed to Primary Care Groups (80%) demonstrating an understanding and high expectation of their community focused role. This high expectation, combined with their relatively low levels of current competency for purpose (54% on average) identifies an important need for public health training in Primary Care Groups.

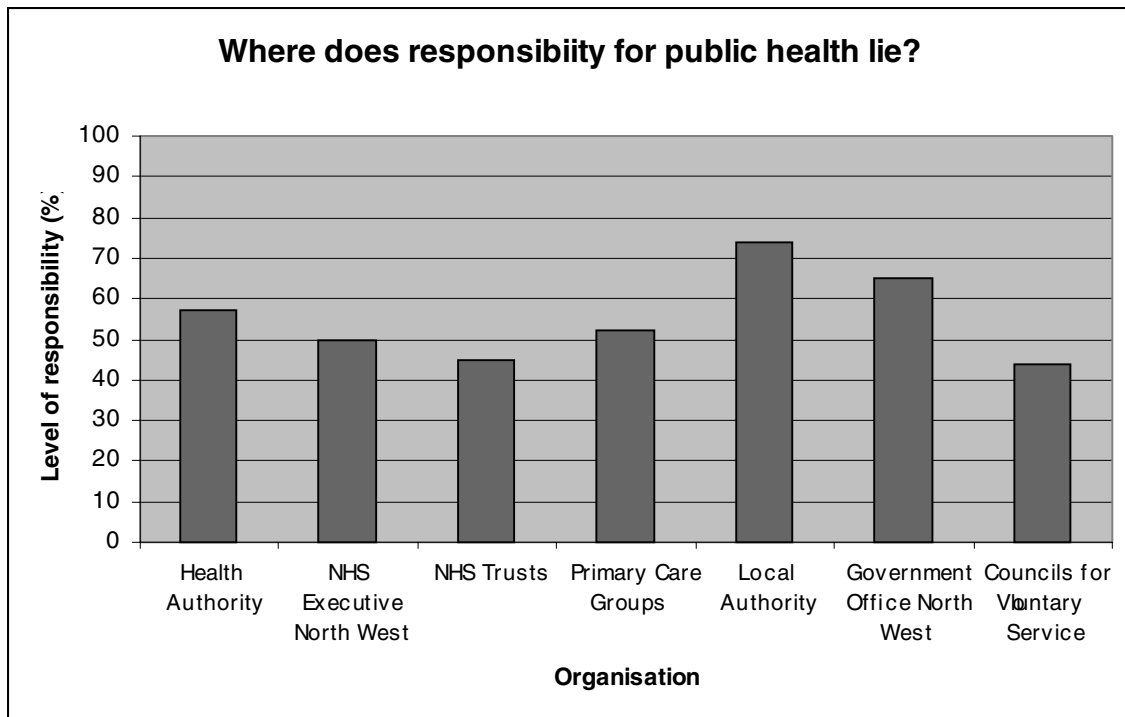
In the area of 'encouraging the public towards healthier lifestyles by promoting exercise and / or healthy eating,' Primary Care Groups were thought to have as much responsibility as Local Authorities although staff working in Primary Care Groups thought that their organisation had more responsibility than Local Authorities.

Staff working for Health Authorities thought their organisation had more responsibility in the area of 'monitoring and addressing pollution' and 'helping ensure people are housed in accommodation which is suitable for their needs' (11% in both cases) than did staff of other organisations. Staff from the NHS Executive North West also thought their organisation had 19% more responsibility than did staff of other organisations in the area of housing. Even

though others perceived that they only had a low level of responsibility in the area of 'helping ensure that public transport is affordable for people on low incomes', once again Health Authority staff thought their own organisation had 10% more responsibility than did staff of other organisations. Health Authority staff appear to think that their organisation should be more involved with tackling the wider determinants of health such as pollution, housing and transport. This misunderstanding may indicate areas of potential conflict, since other organisations think that organisations such as Health Authorities and NHS Executive North West should only have a very moderate to low level of responsibility in these areas.

- Opinion was mixed regarding the burden of responsibility for tackling psychological stress at work and overall organisations were thought to have only a moderate to low level of responsibility with no organisation attributed with a high level of responsibility in this area.

Table 2 Where does responsibility for public health lie? (Using average for all responsibilities.)



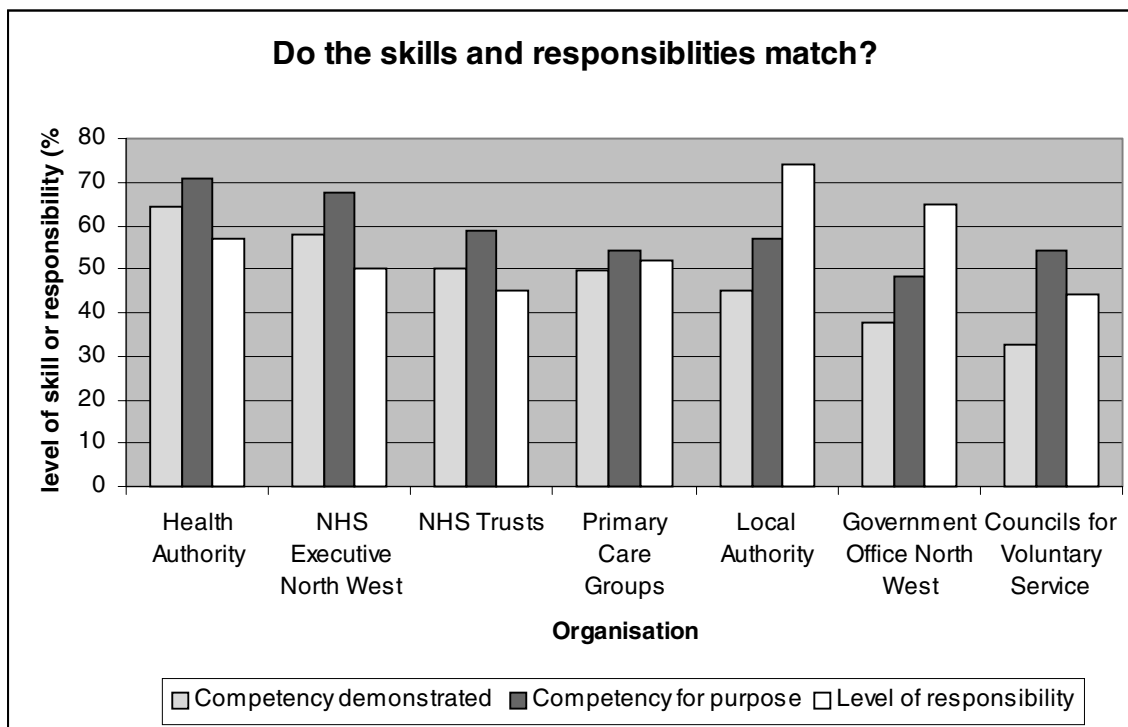
1.2.3 Joint working

- ❑ Reported joint working by staff from Health Authorities with Local Authorities was the highest of any two organisations (94% across all issues). However, the reverse was not true, with Local Authority staff less likely to report joint working with Health Authorities (77% across all issues).
- ❑ Overall NHS Executive North West staff reported the highest average level of joint working across all organisations and all topics (50%) See Table 45.
- ❑ Staff from Councils for Voluntary Service reported the lowest average levels of joint working (23%) followed by NHS Trust staff (29%). However, staff from Councils for Voluntary Service reported high levels of joint working with specific organisations in particular areas (e.g. 83% with Health Authorities in the area of healthy lifestyles).
- ❑ Local Authorities were reported as the organisation most commonly worked with overall, closely followed by Health Authorities. Councils for Voluntary Service, Government Office North West and NHS Executive North West were mentioned least often, but as they are smaller organisations, no conclusions should be drawn from this comparison.
- ❑ Importantly, the prevalence of joint working with ‘sister’ organisations (e.g. Health Authority with other Health Authorities) was low. On average across all issues, 63% of Health Authority staff reported joint working with other Health Authorities with equivalent figures for Local Authorities being lower (50%).
- ❑ The highest degree of joint working across all organisations was reported in the area of ‘health care’ closely followed by ‘healthy lifestyles’ with all other areas approximately equally matched at a lower level of joint working.

1.3 Conclusions

- The major conclusion from this study is that most perceived responsibility for issues that affect public health (as measured by this research) lies with Local Authorities and Government Office, but that most perceived competency in public health skills lies with Health Authorities and NHS Executive. (See Table 3)

Table 3 Match between skills and responsibilities for public health across all organisations



- For many of the areas investigated in the study, one or two organisations were thought to hold high levels of responsibility; but all organisations were thought, by themselves and by others to hold at least some responsibility in every area. The implication of this finding is that all the organisations should be regarded as stakeholders and included in partnership plans.
- Although the study found extensive reports of joint working there was also evidence of misunderstanding and disagreement between organisations about what constitutes joint working; levels of responsibility between different organisations; and who should be involved with what issues.
- Government has made legislative changes to make joint working easier,^{2,3,4} but the facilities provided through legislation cannot be used effectively until there is better understanding of roles and responsibilities within and between organisations. It is not enough simply to require organisations to work in partnerships through legislation and directive. Without accompanying supportive training and management to break down the cultural barriers and improve understanding of the skill base each organisation brings, effective partnerships will remain a pipe dream of Government and the seamless services we all deserve will not be realised.

- That barriers to 'joining up' do exist and need to be removed has been recognised by Government. The Cabinet Office report 'Wiring it up'⁵ suggests that 'More civil servants should be given immediate practical experience of handling conflicts of interest and complex reporting lines of genuine partnership working.'
- Interestingly the two Regional organisations were at opposite ends of the spectrum of misunderstanding of responsibilities. Government Office North West staff felt that its organisation had a lower average level of responsibility for public health issues (than others estimated that it had) and conversely NHS Executive North West staff thought that its organisation had a higher level of responsibility than did staff from other organisations. There is a need to increase capacity and capability, to strengthen joint working and to improve understanding of roles and responsibilities in Government, particularly at Regional level.
- Most staff thought that their organisation was more skilled than others perceived it to be. This study alone cannot identify whose perceptions are correct but results suggest that respondents have difficulty recognising the public health skills in other organisations and that communication between organisations needs to be improved.
- Health Authorities, Local Authorities, NHS Trusts, Primary Care Groups and Councils for Voluntary Service all have clearly defined geographical boundaries and are primarily responsible to the people living in their area. However, the lack of joint working with either organisations of the same type or regional organisations especially in areas such as pollution and transport whose problems cross geographical boundaries suggests a degree of parochialism. Many problems across the Region must have similar aetiologies; and to have people in different offices across the Region working independently on the same issues cannot fail to be inefficient.

1.4 Recommendations

- 1) Publicise the growing need for public health training and expertise (including the ability to work in partnership) throughout all organisations that are connected to public health. This is possibly a role that could be taken on by Government Office North West and the NHS Executive North West in their Regional co-ordinating capacities; a role encouraged by Government⁶.
- 2) Organisations to work together to develop proper partnership criteria that would include channels for communication. The development of this facility is possibly another responsibility that could be taken on by Government Office North West and the NHS Executive North West in their Regional co-ordinating capacities.
- 3) Improve public health skills, including increased training in the ability to develop and work in partnerships, of staff in organisations with a responsibility for the broader determinants of health, but particularly Local Authorities, Government Office and community level organisations. This can be achieved by increasing the capacity of existing courses^a as well as increasing secondment opportunities for public health trained staff to work in other organisations and developing systems to share best practice.

^a One example is the Sokrates Programme (<http://www.phpu.org.uk>)

- 4) Ensure that sufficient resources are available to all organisations to endorse recommendation 3. Money for public health development should be available to all organisations. Until such time as organisations can sustain public health training from their own budgets, some money from pooled Health Authority and Local Authority budgets should be made available to fund public health training courses for staff from a wide range of organisations. There is a need for an improved public health skill base across a wide range of organisations as well as a better understanding by many organisations' staff of the public health roles and skills of *other* organisations.
- 5) Encourage further research to discover the reasons for the anomalies identified here such as the different levels of joint working reported by different organisations. A fundamental of joint working must be that all partners at least realise that they are engaged in such a process. The implementation of pilot partnership projects and analysis of their effectiveness will help determine best practice in terms of partnership working for public health.
- 6) Increase communication through regular multi-sectoral gatherings between all organisations involved with public health, so that each can better understand what the others are doing. This might be a role best taken on by the NHS Executive North West Regional Office as it requires high-level management commitment in order that such meetings are given high priority by staff.
- 7) Make explicit the complementary nature of the responsibilities for the broader determinants of health in all organisations, but especially between Local Authorities and Regional organisations in order to prevent confusion, avoid problems with joint working and encourage the development of effective partnerships. Encourage all organisations to carry out health and / or integrated impact assessments on all new policies, any major policy modifications and all new development projects to increase awareness of the relationship between development and health and use this as the basis for building partnerships.
- 8) Continue work to change the insular culture of organisations, through explicit management efforts to change the bureaucratic nature of public organisations. (Appropriate management training should be regarded as part of the public health skill base.)
- 9) Encourage joint working across geographical boundaries where this would be beneficial to public health – such as monitoring and dealing with pollution and transport. Increase the level of joint working, particularly with Regional organisations and strengthen their role in providing strategic leadership and co-ordination.

2 Introduction

Public health can be described as 'The art of applying science in the context of politics so as to reduce inequalities in health while ensuring the best health for the greatest number.'⁷ Politics in this context refers to the decisions that are made about who gets what in society and who determines the development of policies and programmes that affect health.

The Dahlgren and Whitehead diagram indicates some of the broad range of factors that determine the public's health.

Figure 1 The determinants of health¹



The diagram shows that a complex web of factors surrounding every individual determines their health. A variety of social and public policies as well as behaviour relating to individual lifestyle are central to public health; through their influence on the way people live and engage with each other. Public health has received more attention since the election of the Labour Government in 1997 and the subsequent appointment of the first Minister for Public Health. The Government has sought to redirect the focus of the National Health Service (NHS) and other organisations from the treatment of ill health to the promotion of positive health, a change that recognises the importance of social policy and the broader determinants of health. 'The Government recognises the complex causes of ill health and the part that economic and social factors have to play. It also recognises the fundamental inequalities in health.'² Determinants of health such as age, sex and hereditary factors are important, but they are fixed. Lifestyle, living and working conditions, the environment and several other factors are under individual or collective human control and are therefore open to modification. The extent to which any individual has control over lifestyle is difficult to determine or quantify. So many decisions reflect a combination of the availability of resources and the influence of different norms and values inherent in the cultures that exist in our society. For example, without better education, encouragement, support and service provision, an overworked impoverished mother would find it virtually impossible to take the appropriate physical exercise now, that could help prevent heart disease later in life.

Part of the problem with public health is that it covers almost anything and everything. Policies relating to disparate factors such as housing, transport, education and the environment can all promote public health by providing a safe

environment and facilitating healthy choices. Making the healthy choices attractive and easy involves an entire array of people with influence over the broader determinants of health. Government, Local Authorities, other organisations, individuals and communities as well as Health Authorities can all influence public policies and their implementation. Acheson said that 'Central and local Government, the voluntary sector, industry, the media, the private sector and the individual all have either responsibilities or a contribution to make.'⁸ Public health really is everybody's business.

Public health practice does not seek to take responsibility for every individual's health, but rather to understand and influence the politics that determine health and apply scientific knowledge to the organised efforts employed to promote and protect the public's health.

Appreciation of the complexity of the web of the determinants of health and the multi-sectoral nature of public health leads to questions such as; who decides what contribution each organisation should make? How are decisions about roles and responsibilities made and co-ordinated? An effective public health strategy must seek to harmonise the joint activity of all the groups and individuals working for the benefit of the public's health.

Government's public health strategy described in the White Paper 'Saving Lives: Our Healthier Nation'⁹ is 'based on a three way partnership between people, local communities and Government'. The White Paper acknowledges the complex, interwoven factors that determine health and supports the view that good health for everyone in Britain will only be achieved by joint effort. (Box 1)

Box 1 Government public health strategy

*'The goals of this strategy will be achieved only by a joint effort.'*⁹

Saving Lives; Our Healthier Nation

The strategy described in ‘Saving Lives: Our Healthier Nation’⁹ builds on and complements earlier work by Government laid out in the White Paper on reorganising the National Health Service (Box 2) as well as ‘The NHS Plan’¹⁰.

Box 2 Reorganisation of the NHS

Health Authorities will work closely with NHS Trusts, The new Primary Care Groups, Local Authorities, academic and research interests, voluntary organisations and the local community in devising this new strategic approach...

Lead responsibility for improving overall health and reducing inequalities will be at the heart of the new Health Authority role ...but Health Authorities will not work alone. They will act in partnership with Local Authorities and others to identify how local action on social, environmental and economic issues will make most impact on the health of local people....

Government intends to place on Local Authorities a duty to promote the economic, social and environmental well being of their areas. This will ensure they have clear powers to develop partnerships with a wide range of other organisations, including NHS bodies, to address the needs of local communities.

The New NHS: Modern Dependable¹¹.

As Minister for Public Health, Tessa Jowell said that ‘The Government rejects the old notion that the state can somehow organise the country in such a way as to ensure that people become healthier automatically ... Without individuals, families and communities working together, Government achievements will be limited. Without Government playing its full part, as we found in the past, communities and individuals will struggle to make a real difference. The new public health is about *partnership* and mutual *responsibility* at all levels of society – individual, community and national. It is as much about the wider socio-economic and environmental policies as it is about those policies that fall within the portfolio of the Department of Health’¹²

Government emphasis on partnerships acknowledges the reality that many organisations are active and have a role in promoting and protecting public health and through its White Papers and The Health Act 1999 has legislated the duty of partnership between organisations (Box 3).

Box 3 Duty of partnership

Tackling poor health and inequality needs NHS and local Government to take joint responsibility.

Through the Health Act 1999, we have extended the existing duty of partnership between Health Authorities and Local Authorities to NHS Trusts and Primary Care Trusts (when established.)

Saving Lives: Our Healthier Nation⁹

Effective partnership working adds value to what any one organisation can achieve alone and has several advantages for public health. These include:

- Providing a co-ordinated 'seamless' service for the public
- Avoiding duplication
- Allowing sharing of scarce resources, including expertise
- Increasing overall efficiency
- Enabling a shared vision and encouraging partners to work towards the same goals
- Empowering stakeholders
- Overcoming barriers such as lack of communication between stakeholders working in similar areas
- Providing a greater source of strength and encouragement to all those involved.

A recently published Kings Fund Report *Improving London's Health* argues that 'the Greater London Authority's new responsibilities for regeneration, transport and community safety will enable it to tackle the stark health inequalities that divide Londoners. The report calls for a health strategy for the capital to ensure that each of the Greater London Authority's major policies takes account of health. The report shows how Mayors in other major cities have managed to raise standards of health by prioritising the needs of the poorest and most vulnerable, by building partnerships across sectors and by motivating people to take pride in their city and themselves'¹³.

The importance of partnership work to public health practice is further expressed in the 'Feasibility of the case for national standards for specialist practice in public health', where it is reasoned that 'While (*public health*) specialists may currently work chiefly within health services, dominant components of the determinants of health are located well beyond the scope of the health services. ... There must be explicit

recognition that most of health is determined outside the health care sector and that public health specialists may, therefore work in a variety of settings and must work in partnership with all those responsible, to any degree, for health and with communities themselves.¹⁴

Box 4 describes the Government's vision of what successful partnership working means.

Box 4 The meaning of partnership working

Successful partnership working is built on organisations moving together to address common goals; on developing in their staff the skill necessary to work in an entirely new way – across boundaries, in multi-disciplinary teams, and in a culture in which learning and good practice are shared. It also means:

- *clarifying the common purpose of the partnership*
- *recognising and resolving potential areas of conflict*
- *agreeing a shared approach to partnership*
- *strong leadership based on a clear vision and drive, with well developed influencing and networking skills*
- *continuously adapting to reflect the lessons learned from experience*
- *promoting awareness and understanding of partner organisations through joint training programmes and incentives to reward effective working across organisational boundaries.*

Saving Lives: Our Healthier Nation⁹

For organisations not used to working in partnership, the new Government strategy sets a challenge. Even for groups or organisations that fully understand the benefits of joint working and that support the Government's strategy, effective partnerships are not accomplished easily.

Whenever partnerships are set up, organisational boundaries for responsibilities are initially fluid. The potential for confusion about roles and responsibilities arises and can lead to,

- duplication or omission of service provision
- exploitation of one partner by another
- lack of co-operation
- an increased workload, through increased numbers of meetings etc

All or any of these problems can lead to ill feeling, hostility, lack of progress and low levels of effectiveness.

Differences in organisational culture are not always recognised and power struggles to maintain perceived areas of responsibility occur. In such circumstances partnerships fail to deliver the potential benefits of 'joined – up' programmes to the public.

Partnerships require continuous effort if they are to become effective agents for change. Barriers need to be openly identified and addressed. 'Partners need to build up their relationships at the same time as they focus their attention on the tasks of the partnership. This is because effective partnership is based in mutual understanding, trust and respect.'¹⁵ To achieve success, 'Partners need to agree on shared aims and goals and establish good channels of communication.'¹⁶



One of the key elements in successful partnership working is understanding and appreciating the roles and responsibilities of the other partners. 'Many of the barriers that exist between organisations whose activities impact on health and health services are related to the different roles and responsibilities, constitutions and organisational structures bequeathed by history *That's not how we do things.*'¹⁵

Successful partnerships can only be formed when partners recognise and accept each other's differences, strengths, weaknesses and history, but then work to overcome the barriers and cultural inertia inherent in organisations.

2.1 Skills for public health

Due to the diverse nature of the activities involved, it can be extremely difficult to define and therefore measure public health functions and skills.

Originally, the post of Medical Officer of Health, responsible for public health was attached to temporary Boards of Health in periods of epidemic crisis only. The first full time Medical Officer of Health was William Henry Duncan, appointed to the Borough of Liverpool in 1847. Duncan worked in a multidisciplinary team with Newlands, the Borough Engineer and Thomas Fresh the Sanitary Inspector. Public Health was always regarded as a speciality of the medical profession, but it remained a Local Authority responsibility until 1974 when it was transferred to the Health Authority. From 1974 the Local Authority involvement in health was restricted to environmental issues. All community health services, including district nurses, immunisations, and school health were transferred to the Health Authority. The power and authority of the Local Authority was significantly reduced with the loss of its public health and other responsibilities.

The acknowledged wider determinants of health provide a description of the context in which public health expertise is needed, and include functions as diverse as the provision of healthy housing to the promotion of exercise. Organisations have legislated responsibilities, but the boundaries between Local Authorities, Health Authorities and others are increasingly becoming blurred as organisations try to work together to produce a seamless service for the public. The strict divisions of authority and responsibility characteristic of the 1970s and 1980s resulted in a provider centred perspective with many public health issues falling into the gaps between organisations and then failing to be addressed. For example, where did responsibility lie for ensuring that people with special needs are housed in appropriate accommodation or that people living in poorer areas of the town have equal access to health and other services? These and so many other important

issues for the public cross organisational boundaries and can only be tackled successfully through joint working, and shared responsibility. The public health function therefore lies across many organisations. 'Effective joint working that puts people's needs before the convenience of the organisation is a major challenge.'³

Progress in public health involves moving on a continuous spiral. Many of the concepts and ideas of an earlier era are being revisited, but not in the same way. Public health needs to build on the successes of the past, such as the use of a multidisciplinary approach to problems, even though the public health functions and responsibilities of today lie with a far broader range of organisations than in the past. To provide the efficient seamless services required by today's public, organisations that have their own structures, hierarchies and primary responsibilities, need to move beyond their fundamental roles and work in partnership with other organisations. Organisations must overcome the fear of loss of power, control and authority to assume the challenge and rewards of partnership working.

In 'Wiring it up,'⁵ Prime Minister Tony Blair acknowledges that 'Many of the biggest challenges facing Government do not fit easily into traditional Whitehall structures.' The report sets out a comprehensive package of measures to improve the way Government handles cross-cutting issues. One of the main recommendations is that civil servants need to be better equipped with the skills and capacity to address cross-cutting issues and problems.

To get the best out of organisations in the partnership situations that public health now occupies requires a clear understanding of what each organisation has to offer and what their roles and responsibilities are or should be. A prerequisite for partnership working is 'a clear common purpose.'¹⁵ When the public health function was primarily under one roof this was easier to achieve. Now that many organisations are involved, their public health functions needs to be made more explicit, so that every organisation knows what the others are doing and how each fits into the bigger picture.

Current Government policy increasingly emphasises the broad approach to health, which sets the framework for an increasing need to build capacity and capability in public health. The first key objective of the North West Region's public health and health policy directorate is 'to provide public health leadership and continue to develop the capacity and capability to improve public health in the North West.'¹⁷

A wide range of policies in which local Government, communities or other organisations take the lead are increasing demands for public health capacity in various settings. Health Improvement Programmes (HIMPs) are the primary vehicles for the delivery of a co-ordinated public health agenda, but Health Action Zones, local transport plans, urban regeneration programmes etc., all require broad public health input.

Responsibility for public health

This study seeks to examine the perceived level of responsibility for some of the key factors that determine health as the basis for an examination of where responsibility for public health lies. Included are responsibilities as diverse as promotion of walking and cycling; monitoring and addressing of pollution and working with community and other groups to promote health. (see Appendix 1 for full questionnaire). This information will be essential to underpin successful partnership working for public health in the future.

Public health skills

The 'Feasibility study of the case for national standards for specialist practice in public health'¹⁴ suggests that although public health practice requires a wide range of skills, a set of key competencies and core objectives can be developed to which standards might apply in order to improve the public's health:

- Understanding health and disease; measuring health status
- Disease surveillance and control
- Promoting health and well-being
- Evaluating and improving the effectiveness and efficiency of health care
- Evidence based decisions, information management and research
- Advocacy
- Communication and co-ordination
- Inter-sectoral and collaborative working
- Management and leadership
- Modelling the future of public health

The standards committee of the Faculty of Public Health Medicine of the Royal College of Physicians¹⁸ has more recently developed these into twelve core elements of public health practice covering a similar range of themes.

For this study, the essence of the ten listed core competencies was condensed into five generic public health skills and used as the basis for an examination of the public health competency demonstrated by organisations. This information was used to examine whether organisations with substantial public health functions and responsibilities possess the required level of competency in public health skills.

The five generic public health skills used in this study are;

- Understanding the determinants of health and disease
- Preventing disease and illness
- Promoting health and well-being
- Evaluating health related evidence and research and making decisions accordingly
- Collaborating with other professionals, groups and disciplines contributing to public health

Joint working in public health

The future of public health practice lies in partnerships across several organisations. This study aimed to identify the extent to which organisations are ready for partnership working by looking at not only the match between public health functions and skills across and between organisations, but also how well organisations understand each other's functions and competency. A further indication of the willingness of organisations to work in partnership can be ascertained by examining the extent to which they currently work jointly, especially in areas where several organisations have a high level of responsibility.

Different perceptions between organisations about levels of responsibility and joint working may also give some indication of potential misunderstandings and areas that need to be tackled now to prevent problems with communication and partnership working in the future.

3 Aims and objectives of the study

3.1 Aims

- ❑ To measure public health capacity by examining the level of responsibility for a number of factors that determine health demonstrated by seven organisations that are engaged in and have a high degree of influence over public health policies and practices.
- ❑ To measure public health capability by examining the match between public health competencies needed to perform their duties effectively at the appropriate level; and those demonstrated by the seven organisations.
- ❑ To examine the extent of joint working between seven types of organisation in the North West.
- ❑ To ascertain the extent to which organisations are ready for partnership working by identifying misunderstandings between organisations.
- ❑ To identify gaps and inform decisions about public health capacity training and skill building.
- ❑ To inform decisions about the effective and equitable use of funds to improve public health.

3.2 Objectives

For their own as well as the other six organisations included in this study;

- ❑ To map perceived level of responsibility in fifteen areas known to affect public health.
- ❑ To measure perceived competency in five important public health skills.
- ❑ To reveal the match between current levels of competency and the levels of competency needed to perform their public health duties effectively in five important public health skills.
- ❑ To compare differences in perceived responsibilities and skills described by senior people working within each organisation, with those working in the other organisations.
- ❑ To broadly map joint working between organisations on eight key issues affecting public health.

4 Methodology

Increasingly the public health function revolves around partnership working across organisations. This study seeks to discover capacity for public health and partnership working by examining the current understanding of roles and responsibilities in seven organisations involved with delivering the public health agenda. It seeks to complement the work on estimating the public health workforce being conducted by the capacity and capability working group of the Chief Medical Officer's project to strengthen the public health function. Since it was considered impossible to objectively measure roles and responsibilities, this study examined perceptions and differences in perceptions between high level staff working in different types of organisations, all connected with public health.

Organisations were chosen to represent the range of organisations with responsibility for public health, that operate at local, district and regional levels. Routine data about public health such as mortality and morbidity rates give an indication of the health status of a population, but do not inform about the ability of an organisation to carry out public health skills since they fail to take important external factors into consideration. Judgements about public health capability used in this study are subjective rather than absolute, but they provide valuable information of a comparative nature from key stakeholders.

A questionnaire was developed and sent out to senior staff (in August 1999) from seven different organisations within the North West Region (defined by the area covered by NHS Executive North West.) Questionnaires were sent to

- Chief Executive and Director of Public Health in each Health Authority;
- Chief Executive and Chief Environmental Health Officer in each Local Authority;
- Chief Executive and Chairperson in each Primary Care Group;
- Chief Executive and Medical Director in each NHS Trust;
- Chief Officers in each Council for Voluntary Service;
- Staff at Government Office North West;^b
- Staff at NHS Executive North West.²

The first section of the questionnaire (see Appendix 1) sought to elicit information about perceptions of level of responsibility for fifteen determinants of public health. For their own organisation and the other six organisations individually, respondents were asked to estimate the level of responsibility for each health determinant on an open scale from 'no responsibility' to a 'high level of responsibility'.

The second section of the questionnaire sought to discover perceptions about organisations' required levels of competency and actual levels of competency in five public health skills. Thus, for their own organisation and the other six organisations individually, respondents were asked to identify the level of competency *actually demonstrated* by the organisation and the level of competency the organisation *should* possess to perform effectively. Respondents marked their opinions using another open scale from 'not at all competent' to 'fully competent' for each skill.

The third section of the questionnaire sought to discover perceptions of the extent of current joint working and asked about which organisations each respondent or their organisation worked together with over a series of public health issues.

^b Staff surveyed at Government Office North West and NHS Executive North West were few in number and will not be identified to protect their anonymity.

4.1 Response rate

Staff who failed to respond within the set time period were followed up with a phone call or letter and in some instances when the first had been mislaid, a second questionnaire was sent out.

The overall response rate was 41%. However, this varied considerably, from a high of 88% from Directors of Public Health to 28% from Chairs of Primary Care Groups. Spoiled or incomplete questionnaires (three in total) were excluded from the analysis.

Table 4 Response rate

Organisation	Number of questionnaires;		Response rate %
	Sent out	Returned	
<i>Health Authority</i>	32	27	84
Chief Executives	16	13	81
Directors of Public Health	16	14	88
<i>Local Authority</i>	80	35	44
Chief Executives	41	24	59
Chief Environmental Health Officer	39	11	28
<i>NHS Trust</i>	116	39	34
Chief Executives	58	20	35
Medical Directors	58	19	33
<i>Primary Care Group</i>	130	48	37
Chief Executives	65	30	46
Chairs	65	18	28
<i>Council for Voluntary Service</i>	37	12	32
Chief Officers	37	12	32
<i>Government Office North West</i>	5	2	40
<i>NHS Executive North West</i>	4	3	75
Total	404	166	41

4.2 Analysis

For the sections examining public health responsibilities and public health skills, each mark on the scale was measured and converted to a score equivalent to a percentage of the highest possible mark. Scores were aggregated according to organisation and mean scores were calculated for each area.

4.2.1 Public health skills

For each organisation, the following were calculated for each skill,

- Mean score for competency currently demonstrated (%)
- Mean score for competency needed to perform effectively (%)
- Competency for purpose expressed as a percentage (i.e. competency currently demonstrated / competency needed x 100). Only scores from respondents who marked the organisation for both needed as well as currently demonstrated competency were included in the calculation for competency for purpose.
- Mean score for competency needed to perform effectively given by staff working **inside** that organisation (%)
- Mean score for competency needed to perform effectively given by staff working **outside** the organisation (%)
- Difference between mean scores given by staff working in the organisation compared to staff working outside the organisation.

4.2.2 Responsibility for determinants of health

For each organisation, the following were calculated for each public health responsibility;

- Mean score for estimate of level responsibility (%)
- Mean score for estimate of responsibility given by staff working **inside** the organisation (%)
- Mean score for estimate of responsibility given by staff working **outside** the organisation (%)
- Difference between mean scores given by staff working in the organisation compared to staff working outside the organisation.

For both skills and responsibilities a two sample t-test was used to calculate any significant differences between the mean scores given by staff working in the organisation compared to staff working outside the organisation. Any significant difference at the 5% level was noted in the results with an asterisk*. Significant difference at the 1% level was noted with a double asterisk**.

Kendall's coefficient of concordance was used as a measure of how closely opinions of individuals from the same organisation agreed, as well as to measure the similarity of opinions from different organisation. When using this statistic, the smaller the p-value, the more likely it is that groups rank each organisation in a similar fashion and the less likely it is that the differences between rankings are due to chance.

4.2.3 Joint working

- For each organisation, the percentage of respondents who reported joint working in each area of public health was calculated.

5 Results

5.1 Public Health Skills

There are two Tables on each page in this section, describing the results for each of the five public health skills examined. (Tables 5 to 14)

In each Table, results from the Health Authorities and the Local Authorities, which operate at district level, are in the top band. The more local level organisations such as NHS Trusts, Primary Care Groups and the Councils for Voluntary Service come in the middle band. Results from the two regional level organisations, Government Office North West and NHS Executive North West are presented in the lowest band.

In the first Table on each page, (i.e. Tables 5, 7, 9, 11 & 13) competency is described for each organisation.

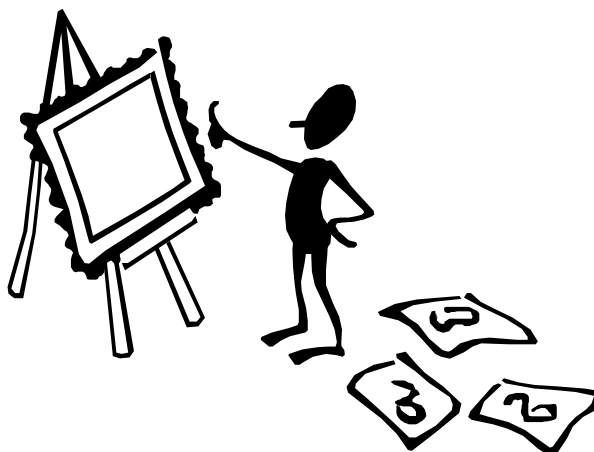
- The first column lists the organisations studied.
- The second column (a) describes the current level of competency attributed to the organisation
- The third column (b) describes the competency needed to perform effectively.
- The fourth and last column describes *competency for purpose* and is a measure of how closely the organisation achieves the level of competence required in each skill surveyed ($a / b \times 100$).

In the second Table on each page, (i.e. Tables 6, 8, 10, 12 & 14) the opinions of staff working for each organisation are compared to the opinions of staff working for all other organisations combined.

- The first column lists the organisations studied.
- The second column gives the current competency rating given by staff of the organisation.
- The third column gives the competency rating by staff from all the other organisations combined.
- The fourth and last column describes the difference between competency rating given by staff working in the organisation compared to the opinions of staff working for all other organisations combined.

Any apparent minor irregularities between the two columns can be ascribed to differences caused by rounding the figures.

A t-test was applied only to the difference between self and other ratings in the second Table on each page. Sometimes, apparently high levels of disagreement were not found to be significantly different. This was due to the low numbers of people surveyed in some of the organisations, particularly Government Office North West and NHS Executive North West.



5.1.1 Understanding the determinants of health and disease

5.1.1.1 Competency perceptions

Table 5 Competency in understanding the determinants of health and disease

Organisation	(a) Competency demonstrated %	(b) Competency required %	Perceived competency for purpose (%) [*]
Health Authority	74	87	83
Local Authority	47	75	68
NHS Trusts	56	78	58
Primary Care Groups	56	85	61
Councils for Voluntary Service	31	54	51
Government Office North West	42	69	52
NHS Executive North West	67	85	77

^{*} Perceived competency for purpose is calculated by dividing competency demonstrated by competency required expressed as a percentage. Occasionally, this will differ from dividing columns a by b as only results from respondents providing both demonstrated and required competency were used to calculate this percentage.

5.1.1.2 Rating by own staff compared to rating by other staff

Table 6 Rating by own staff compared to rating by other staff for competency in understanding the determinants of health and disease

Organisation	Own staff	Other staff	Difference
Health Authority	76	74	+3
Local Authority	55	45	+10*
NHS Trusts	65	54	+11*
Primary Care Groups	54	57	-3
Councils for Voluntary Service	34	31	+4
Government Office North West	46	42	+5
NHS Executive North West	65	67	-2

* Indicates that difference is statistically significant at the 5% level

The ability to understand the determinants of health was recognised as an important skill that required a high level of competence from many organisations. However, for most organisations the difference between required and demonstrated competency was substantial. Staff from both Local Authorities and NHS Trusts thought that their own organisation had significantly higher levels of skill in understanding the determinants of health than was perceived by staff in other organisations. This indicates an important difference of opinion between respondents employed by and those employed outside these organisations over the level of public health competency demonstrated.

5.1.2 Preventing disease and illness

5.1.2.1 Competency perceptions

Table 7 Competency in preventing disease and illness

Organisation	(a) Competency demonstrated %	(b) Competency required %	Perceived competency for purpose (%) [*]
Health Authority	62	85	69
Local Authority	42	72	52
NHS Trusts	50	77	64
Primary Care Groups	52	84	59
Councils for Voluntary Service	30	50	54
Government Office North West	35	63	47
NHS Executive North West	57	80	68

^{*} Perceived competency for purpose is calculated by dividing competency demonstrated by competency required expressed as a percentage. Occasionally, this will differ from dividing columns a by b as only results from respondents providing both demonstrated and required competency were used to calculate this percentage.

5.1.2.2 Rating by own staff compared to rating by other staff

Table 8 Rating by own staff compared to rating by other staff for competency in preventing disease and illness

Organisation	Own staff	Other staff	Difference
Health Authority	63	61	+3
Local Authority	52	38	+14 ^{**}
NHS Trusts	54	48	+6
Primary Care Groups	53	51	+2
Councils for Voluntary Service	24	30	-6
Government Office North West	41	35	+6
NHS Executive North West	67	57	+11

^{*} Indicates that difference is statistically significant at the 5% level

^{**} Indicates that difference is statistically significant at the 1% level

Chief Executives of both Health Authorities and Primary Care Groups thought that all the organisations had lower levels of competency than did Directors of Public Health and Chairs of Primary Care Groups. Chief Executives of NHS Trusts thought that all organisations had a higher level of competency than did their Medical Directors. (Data not shown.)

Local Authorities and Government Office North West demonstrated low levels of competency (42/100 and 35/100 respectively) as well as the lowest levels of competency for purpose (52% and 47% respectively). Staff from Local Authorities also estimated the competency of Local Authorities considerably higher than did staff of other organisations. These anomalous responses indicate a misunderstanding of either the role of the Local Authority, or the ability of Local Authorities to prevent disease and illness.

5.1.3 Promoting health and well-being

5.1.3.1 Competency perceptions

Table 9 Competency in promoting health and well being

Organisation	(a) Competency demonstrated %	(b) Competency required %	Perceived competency for purpose (%) [*]
Health Authority	62	84	69
Local Authority	49	79	56
NHS Trusts	47	75	57
Primary Care Groups	50	83	53
Councils for Voluntary Service	36	57	56
Government Office North West	37	68	45
NHS Executive North West	53	79	63

^{*} Perceived competency for purpose is calculated by dividing competency demonstrated by competency required expressed as a percentage. Occasionally, this will differ from dividing columns a by b as only results from respondents providing both demonstrated and required competency were used to calculate this percentage.

5.1.3.2 Rating by own staff compared to rating by other staff

Table 10 Rating by own staff compared to rating by other staff for competency in promoting health and well-being

Organisation	Own staff	Other staff	Difference
Health Authority	64	62	+3
Local Authority	56	47	+9*
NHS Trusts	51	46	+5
Primary Care Groups	46	52	-6
Councils for Voluntary Service	35	36	-1
Government Office North West	37	37	+1
NHS Executive North West	65	53	+13

* Indicates that difference is statistically significant at the 5% level

Chief Executives from both Health Authorities and Primary Care Groups rated all organisations with lower levels of competency than did Directors of Public Health and Chairs of Primary Care Groups. Chief Executives of NHS Trusts rated organisations with higher levels of competency than did Medical Directors of NHS Trusts. (Data not shown.) Respondents thought that Primary Care Groups should demonstrate a high level, (83%) but that they only demonstrated around half of the competency required in promoting health and well being. Again both Local Authorities and Government Office North West were perceived to have relatively low levels of competency for purpose (56% and 45% respectively). Staff from Local Authorities again estimated the competency of Local Authorities higher than did staff of other organisations, indicating further misunderstanding of either the role or the ability of Local Authorities to promote health and well being.

5.1.4 Evaluating health-related evidence and research then making decisions accordingly

5.1.4.1 Competency perceptions

Table 11 Competency in evaluating health-related evidence and research then making decisions accordingly

Organisation	(a) Competency demonstrated %	(b) Competency required %	Perceived competency for purpose (%)*
Health Authority	63	86	68
Local Authority	34	68	48
NHS Trusts	51	81	60
Primary Care Groups	43	83	47
Councils for Voluntary Service	22	45	51
Government Office North West	33	64	49
NHS Executive North West	59	82	68

* Perceived competency for purpose is calculated by dividing competency demonstrated by competency required expressed as a percentage. Occasionally, this will differ from dividing columns a by b as only results from respondents providing both demonstrated and required competency were used to calculate this percentage.

5.1.4.2 Rating by own staff compared to rating by other staff

Table 12 Rating by own staff compared to rating by other staff for competency in evaluating health-related evidence and research then making decisions accordingly

Organisation	Own staff	Other staff	Difference
Health Authority	67	62	+5
Local Authority	39	32	+7
NHS Trusts	58	49	+10*
Primary Care Groups	42	44	-2
Councils for Voluntary Service	26	22	+4
Government Office North West	45	33	+12
NHS Executive North West	68	59	+9

* Indicates that difference is statistically significant at the 5% level

Chief Executives of NHS Trusts rated all organisations with slightly higher levels of competence than did their Medical Directors. Chief Executives of Primary Care Groups rated all organisations with lower levels of competence than did their Chairpersons. (Data not shown.) Respondents thought that most organisations involved should possess a high degree of competency in this area. Local Authorities, Primary Care Groups and Government Office North West were perceived to have less than half the competency they needed to perform effectively. Respondents thought that NHS Trusts should be highly competent in this area (81%). Staff working for NHS Trusts considered that NHS Trusts demonstrated a higher level of competency in this area than was perceived by staff from other organisations.

5.1.5 Collaborating with other professions, groups and disciplines contributing to the health of the public

5.1.5.1 Competency perceptions

Table 13 Competency in collaborating with other professions, groups and disciplines contributing to the health of the public.

Organisation	(a) Competency demonstrated %	(b) Competency required %	Perceived competency for purpose (%) [*]
Health Authority	60	86	66
Local Authority	54	82	62
NHS Trusts	46	78	55
Primary Care Groups	48	84	52
Councils for Voluntary Service	44	66	60
Government Office North West	41	75	48
NHS Executive North West	53	81	61

^{*} Perceived competency for purpose is calculated by dividing competency demonstrated by competency required expressed as a percentage. Occasionally, this will differ from dividing columns a by b as only results from respondents providing both demonstrated and required competency were used to calculate this percentage.

5.1.5.2 Rating by own staff compared to rating by other staff

Table 14 Rating by own staff compared to rating by other staff for competency in collaborating with other professions, groups and disciplines contributing to the health of the public

Organisation	Own staff	Other staff	Difference
Health Authority	66	59	+8
Local Authority	64	52	+12**
NHS Trusts	55	43	+12**
Primary Care Groups	50	48	+2
Councils for Voluntary Service	48	44	+4
Government Office North West	78	40	+38*
NHS Executive North West	46	53	-7

* Indicates that difference is statistically significant at the 5% level

** Indicates that difference is statistically significant at the 1% level

Chief Executives of both Health Authorities and Primary Care Groups rated organisations with a lower level of competency did than Directors of Public Health and Chairpersons of Primary Care Groups. (Data not shown.) Respondents (except those from NHS Executive North West) thought that their own organisation was more competent at collaborating with other professionals than was perceived by staff from other organisations. This difference was highly significant for both Local Authorities and NHS Trusts. Respondents thought that every organisation apart from the Councils for Voluntary Service should be highly competent (more than 70%) in this area.

5.2 Findings for public health skills

The results show that Health Authorities were not only regarded as the most competent but also the organisation that should be the most competent in all five skills studied. Respondents felt that overall Health Authorities demonstrated 71% of the competency required for purpose, leaving considerable room for improvement. Primary Care Groups closely followed Health Authorities as the organisation requiring the second highest level of competency in public health skills but demonstrated only 54% competency for purpose. NHS Executive North West ranked second in both competency demonstrated and competency for purpose. Local Authorities were only thought to demonstrate an overall 57% competency for purpose. On average, Government Office North West and Councils for Voluntary Service were regarded as the organisations with the lowest level of competency both demonstrated and required and together with Primary Care Groups were thought to demonstrate the lowest levels of competency for purpose. Government Office North West was considered to possess 48%, and both Councils for Voluntary Service and Primary Care Groups 54% competency for purpose across the five public health skills studied.

The need for public health skills throughout the organisations studied is demonstrated by the average level of competency required which ranged from a low of 54% from Councils for Voluntary Service to a high of 86% from Health Authorities. Respondents felt that Local Authorities should possess a high level of competency overall (average of 75%) to carry out their public health functions effectively, but that they fell considerably short of this requirement. This identifies the need for public health skills training across many organisations but particularly for staff working in Local Authorities.

5.2.1 Self and others perceptions

In general, staff rated the public health skills of the organisation where they worked higher than did respondents in other organisations. Interestingly, 'Collaborating with other professions, groups and disciplines contributing to the health of the public' was the skill most commonly rated higher by an organisation's own staff than by respondents working in other organisations.

Health Authority staff rated the competency of Health Authorities higher in every skill area than did other respondents, but differences were small and not statistically significant. Local Authority staff invariably reported that Local Authorities had between 7% and 14% higher level of competency than did respondents working in other organisations. This difference was statistically significant for 4 out of 5 skill areas. NHS Trust staff also reported that NHS Trusts had between a 5% and 12% higher level of competency than did respondents from other organisations. This difference was statistically significant for 3 out of 5 skill areas.

Staff working in Primary Care Groups rated the competency of Primary Care Groups slightly lower (between 1% and 6%) in three skill areas and just 2% higher in two skill areas, than did respondents working in other organisations, but no differences were statistically significant. This variation suggests a degree of uncertainty about the public health competency of the Primary Care Groups, which were in their infancy when the survey was carried out.

Government Office North West staff invariably thought that Government Office North West had between a 1% and 38% higher level of competency than did respondents from other organisations. Government Office North West own staff's rating was 78% compared to other respondents' rating of only 40% for the skill of collaborating with other professions. This difference was statistically significant and demonstrates a considerable level of misunderstanding about either the role and / or the ability of

Government Office North West to collaborate with other professions, groups and disciplines contributing to the health of the public. This is particularly pertinent because the mission statement of Government Office North West is 'To work with regional partners and local people to maximise competitiveness and prosperity in the Region and to support integrated policies for an inclusive society.'¹⁹ Good public health is both a product of and depends on wealth and prosperity and should therefore be an important consideration for Government Office North West's policy development and activities. There was also less agreement about the competency of NHS Executive North West whose own staff rated them between 9% and 13% more competent than did respondents working in other organisations in three skill areas, but between 2% and 7% less competent in two skill areas. No differences were significant and the high level of variation is most likely a result of the low numbers of people at NHS Executive North West who were surveyed.

The inconsistencies found throughout this section supplement the evidence for a considerable level of misunderstanding about public health competencies among and between the organisations involved in the study.

5.2.2 Difference of opinion between staff

Analysis using Kendall's coefficient of concordance identified that, for the four larger organisations the probability (p-value) that the level of agreement between staff from all organisation as well as between different grades of staff was too great to be due to chance ($p < 0.001$ in every case). This indicates a high degree of agreement about the ranking of organisations for public health skills. There was less agreement about the ranking of current competency among staff of Councils for Voluntary Service where the concordance was not significant for the skill of 'promoting of health and well being.' However, here small sample size may have been a factor.

Due to the small numbers of individuals involved, results from the staff of Government Office North West and NHS Executive North West were excluded from this analysis.

5.3 Responsibility for the determinants of health

There are two Tables on each page in this second section, describing the reported results for organisational responsibility for each of fifteen factors that determine public health. (Tables 15 to 44)

In the first Table on each page, organisations are ranked according to the perceived level of responsibility for each determinant of health surveyed.

- The first column gives the ranked position of organisations
- The second column gives the mean level of responsibility attributed to each organisation out of a possible 100 and expressed as a percentage
- The third column names the ranked organisations according to level of responsibility. The organisation at the top of the list is the one with the highest level of responsibility as perceived by all respondents.

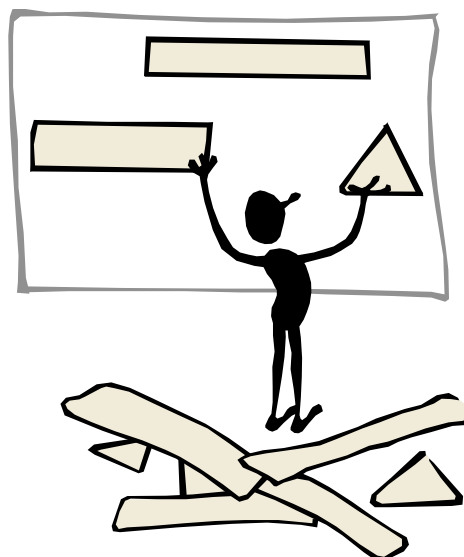
Where the perceived level of responsibility reaches 70% or more the organisation is ascribed with a high level of responsibility. Between 40 – 70% is considered moderate, and a level of responsibility less than 40% is regarded as low.

In the second Table on each page, the opinions of staff working for each organisation are compared to the opinions of staff working for all other organisations combined. As in the previous section, results for Health Authorities and Local Authorities, which operate at district level, are in the top band above the first dotted line. The more local level organisations such as NHS Trusts, Primary Care Groups and Councils for Voluntary Service come in the middle band. Results for the two regional level organisations, Government Office North West and NHS Executive North West are presented in the lowest band.

- The first column lists the organisations studied.
- The second column gives the responsibility rating given by staff of the organisation in each row.
- The third column gives the responsibility rating given by staff from all the other organisations combined.
- The fourth and last column describes the difference between responsibility rating given by the staff working for each organisation compared to the responsibility rating given by staff working for all other organisations combined.

(Any apparent minor irregularities between the two columns can be ascribed to differences caused by rounding the figures.)

A t-test was applied only to the difference between self and other ratings in the second Table on each page. Sometimes, apparently high levels of disagreement were not found to be significantly different, and again this was often due to the low numbers of people surveyed in some of the organisations, particularly Government Office North West and NHS Executive North West.



5.4 Healthy lifestyles

5.4.1 Promoting walking and cycling

All organisations were thought to have a moderate to high level of responsibility for promoting walking and cycling.

Respondents working for Councils for Voluntary Service estimated the level of responsibility of their organisation an average of 10% lower than did respondents from other organisations; indicating that most respondents think Councils for Voluntary Service should have more responsibility in this area.

5.4.1.1 Responsibility

Table 15 Responsibility for promoting walking and cycling

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	73	Local Authority
2	64	Government Office for the North West
2	64	Health Authority
4	55	Primary Care Groups
5	53	NHS Executive North West
6	47	NHS Trusts
7 Least responsibility	41	Council for Voluntary Service

5.4.1.2 Rating by own staff compared to rating by other staff

Table 16 Rating by own staff compared to rating by other staff for promoting walking and cycling

Organisation	Own staff	Other staff	Difference
Health Authority	63	63	0
Local Authority	74	72	+2
NHS Trusts	45	48	-3
Primary Care Groups	56	55	+1
Councils for Voluntary Service	36	46	-10
Government Office North West	67	64	+3
NHS Executive North West	68	52	+16

5.4.2 Promoting healthy lifestyles in schools

Local Authorities and Health Authorities were thought to have a high level of responsibility, with all other organisations having a moderate or low level of responsibility.

NHS Trusts only felt that they had a level of responsibility of 38%, whereas staff of other organisations thought they had a considerably higher level of responsibility (51%). This indicates considerable confusion around the role of NHS Trusts in promoting healthy lifestyles in schools.



5.4.2.1 Responsibility

Table 17 Responsibility for promoting healthy lifestyles in schools

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	80	Local Authority
2	71	Health Authority
3	60	Primary Care Groups
4	56	Government Office North West
5	53	NHS Executive North West
6	47	NHS Trusts
7 Least responsibility	36	Councils for Voluntary Service

5.4.2.2 Rating by own staff compared to rating by other staff

Table 18 Rating by own staff compared to rating by other staff for promoting healthy lifestyles in schools

Organisation	Own staff	Other staff	Difference
Health Authority	73	70	+3
Local Authority	80	79	+1
NHS Trusts	38	51	-13*
Primary Care Groups	62	59	+3
Councils for Voluntary Service	40	35	+5
Government Office North West	31	56	-25
NHS Executive North West	52	54	-2

* Indicates that difference is statistically significant at the 5% level

5.4.3 Encouraging the public towards healthier lifestyles, for example, by promoting exercise and / or healthy eating

All organisations were thought to have a moderate to high level of responsibility for encouraging healthier lifestyles. Primary Care Groups were thought to have as much responsibility as Local Authorities although staff working in Primary Care Groups thought that their organisation had more responsibility than Local Authorities.



Councils for Voluntary Service were thought to have least responsibility for promoting healthier lifestyles by every organisation although staff working for Councils for Voluntary Service thought the organisation had 19% higher level of responsibility than did staff of other organisations combined. This indicates considerable misunderstanding of the role of Councils for Voluntary Service in this area.

5.4.3.1 Responsibility

Table 19 Responsibility for encouraging healthier lifestyles.

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	78	Health Authority
2	73	Local Authority
2	73	Primary Care Groups
4	68	NHS Executive North West
5	64	NHS Trusts
6	62	Government Office North West
7 Least responsibility	51	Councils for Voluntary Service

5.4.3.2 Rating by own staff compared to rating by other staff

Table 20 Rating by own staff compared to rating by other staff for encouraging healthier lifestyles.

Organisation	Own staff	Other staff	Difference
Health Authority	80	78	+2
Local Authority	74	73	+1
NHS Trusts	63	65	-2
Primary Care Groups	77	70	+7
Councils for Voluntary Service	68	49	+19
Government Office North West	33	62	-29
NHS Executive North West	68	68	0

5.4.4 Discouraging people from smoking and using other drugs

Again all organisations were thought to have a moderate to high level of responsibility for discouraging smoking and the use of other drugs. Overall, Health Authorities were thought to have most responsibility for discouraging smoking, although Chief Executives of NHS Trusts and Primary Care Groups as well as staff from Government Office North West all thought that Primary Care Groups have most responsibility.



5.4.4.1 Responsibility

Table 21 Responsibility for discouraging smoking and other drugs

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	82	Health Authority
2	78	Primary Care Groups
3	73	Local Authority
3	73	NHS Trusts
5	71	NHS Executive North West
6	65	Government Office North West
7 Least responsibility	55	Councils for Voluntary Service

5.4.4.2 Rating by own staff compared to rating by other staff

Table 22 Rating by own staff compared to rating by other staff for discouraging smoking and other drugs

Organisation	Own staff	Other staff	Difference
Health Authority	81	82	-1
Local Authority	72	74	-2
NHS Trusts	73	73	0
Primary Care Groups	82	76	+6
Councils for Voluntary Service	57	55	+2
Government Office North West	14	67	-53**
NHS Executive North West	70	70	0

* Indicates that difference is statistically significant at the 5% level

** Indicates that difference is statistically significant at the 1% level

5.5 Healthy settings

5.5.1 Monitoring and addressing pollution of air, water and land

Local Authorities closely followed by Government Office North West were ranked unanimously as having a high level of responsibility for monitoring and addressing pollution. All other organisations were thought to have moderate to low levels of responsibility. Staff working for



Health Authorities thought their organisation had more responsibility (11%) in this area than did staff of other organisations, possibly indicating that Health Authority staff think their organisation should be more involved with tackling the wider determinants of health such as pollution. This misunderstanding indicates an area of potential conflict, since other organisations think that Health Authorities should only have a very moderate to low level of responsibility in this area.

5.5.1.1 Responsibility

Table 23 Responsibility for addressing pollution of air, water and land

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	84	Local Authority
2	73	Government Office North West
3	45	Health Authority
4	42	NHS Executive North West
5	25	Primary Care Groups
6	22	NHS Trusts
6 Least responsibility	22	Councils for Voluntary Service

5.5.1.2 Rating by own staff compared to rating by other staff

Table 24 Rating by own staff compared to rating by other staff for addressing pollution of air, water and land.

Organisation	Own staff	Other staff	Difference
Health Authority	55	44	+11
Local Authority	86	83	+3
NHS Trusts	17	24	-7
Primary Care Groups	29	24	+5
Councils for Voluntary Service	22	22	0
Government Office North West	69	73	-4
NHS Executive North West	61	41	+20*

* Indicates that difference is statistically significant at the 5% level

5.5.2 Helping ensure schools provide a safe environment

Local Authorities followed by Government Office North West were thought to have most responsibility for ensuring schools are safe environments. Other organisations were thought to have far less responsibility with NHS Trusts having least responsibility.

Staff working for the Government Office North West thought their organisation had 43% less responsibility in this area than did staff of other organisations, indicating considerable misunderstanding of the role of Government Office North West in helping ensure schools are a safe environment.

5.5.2.1 Responsibility

Table 25 Responsibility for helping ensure schools provide a safe environment.

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	85	Local Authority
2	62	Government Office North West
3	40	Health Authority
4	35	Primary Care Groups
5	33	NHS Executive North West
6	27	Councils for Voluntary Service
7 Least responsibility	25	NHS Trusts

5.5.2.2 Rating by own staff compared to rating by other staff

Table 26 Rating by own staff compared to rating by other staff for helping ensure schools provide a safe environment.

Organisation	Own staff	Other staff	Difference
Health Authority	42	40	+2
Local Authority	82	86	-4
NHS Trusts	21	27	-6
Primary Care Groups	37	34	+3
Councils for Voluntary Service	27	28	-1
Government Office North West	20	63	-43*
NHS Executive North West	50	32	+18

* Indicates that difference is statistically significant at the 5% level

5.5.3 Helping ensure workplaces in general are safe environments

Local Authorities closely followed by Government Office North West were thought to have a high level of responsibility for ensuring workplaces in general are safe environments. Other organisations were thought to have moderate levels of responsibility with Councils for Voluntary Service only having a low level of responsibility. Staff working for NHS Executive North West thought their organisation had 34% more responsibility in this area than did staff of other organisations, indicating considerable misunderstanding of the role of NHS Executive North West in helping ensure workplaces are safe environments.

5.5.3.1 Responsibility

Table 27 Responsibility for helping ensure workplaces are safe environments

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	76	Local Authority
2	71	Government Office North West
3	53	Health Authority
4	45	NHS Executive North West
5	42	NHS Trusts
5	42	Primary Care Groups
7 Least responsibility	36	Councils for Voluntary Service

5.5.3.2 Rating by own staff compared to rating by other staff

Table 28 Rating by own staff compared to rating by other staff for helping ensure workplaces are safe environments

Organisation	Own staff	Other staff	Difference
Health Authority	53	52	+1
Local Authority	77	76	+1
NHS Trusts	38	43	-4
Primary Care Groups	42	41	+1
Councils for Voluntary Service	38	35	+3
Government Office North West	56	71	-15
NHS Executive North West	79	45	+34**

* Indicates that difference is statistically significant at the 5% level

** Indicates that difference is statistically significant at the 1% level

5.5.4 Tackling psychological stress in workplaces

Opinion was mixed regarding the burden of responsibility for tackling psychological stress at work, and overall organisations were thought to have only a moderate to low level of responsibility. No organisation was attributed with a high level of responsibility in this area. Interestingly, it was in this area, that Health Authority staff most substantially rated the level of responsibility of their own organisation lower than did staff in other organisations.



5.5.4.1 Responsibility

Table 29 Responsibility for tackling psychological stress in the workplace

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	60	Health Authority
1	60	Local Authority
3	58	Government Office North West
4	51	Primary Care Groups
4	51	NHS Executive North West
6	49	NHS Trusts
7 Least responsibility	38	Councils for Voluntary Service

5.5.4.2 Rating by own staff compared to rating by other staff

Table 30 Rating by own staff compared to rating by other staff for tackling psychological stress in the workplace

Organisation	Own staff	Other staff	Difference
Health Authority	53	61	-8
Local Authority	60	60	0
NHS Trusts	42	50	-9
Primary Care Groups	52	51	+1
Councils for Voluntary Service	35	38	-3
Government Office North West	51	58	-7
NHS Executive North West	72	50	+22

5.5.5 Helping ensure people are housed in accommodation which is suitable for their needs

Local Authorities followed by Government Office North West were thought to have most responsibility for helping to ensure that people are housed in accommodation, which is suitable for their needs. Other organisations were thought to have far less responsibility, with NHS Trusts having least responsibility. Staff working for Health Authorities thought their organisation had more responsibility (11%) in this area than did staff of other organisations and similarly, staff from NHS Executive North West thought their organisation had 19% more responsibility than did staff of other organisations. Possibly staff working in Health Authorities and NHS Executive North West understand the importance of housing as a determinant of health and therefore think their respective organisations should be more involved with ensuring suitable housing is provided. This misunderstanding reveals the potential for conflict, since other organisations think that Health Authorities and NHS Executive North West only have a low level of responsibility in this area.

5.5.5.1 Responsibility

Table 31 Responsibility for helping to ensure that people are housed in accommodation which is suitable for their needs

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	85	Local Authority
2	67	Government Office North West
3	42	Health Authority
4	40	Primary Care Groups
4	40	Councils for Voluntary Service
6	35	NHS Executive North West
7 Least responsibility	29	NHS Trusts

5.5.5.2 Rating by own staff compared to rating by other staff

Table 32 Rating by own staff compared to rating by other staff for helping to ensure that people are housed in accommodation which is suitable for their needs

Organisation	Own staff	Other staff	Difference
Health Authority	50	39	+11*
Local Authority	84	84	0
NHS Trusts	25	30	-5
Primary Care Groups	37	40	-3
Councils for Voluntary Service	32	40	-8
Government Office North West	56	67	-11
NHS Executive North West	53	34	+19*

* Indicates that difference is statistically significant at the 5% level

5.6 Health care

5.6.1 Helping ensure there is equitable access to health care in terms of gender, geography, socio-economic status and ethnic background

Health Authorities, Primary Care Groups, NHS Executive North West and NHS Trusts were all thought to have a high level of responsibility for ensuring equitable access to health care.

5.6.1.1 Responsibility

Table 33 Responsibility for ensuring equitable access to health care

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	84	Health Authority
2	80	Primary Care Groups
3	78	NHS Executive North West
4	76	NHS Trusts
5	60	Government Office North West
6	51	Local Authority
6 Least responsibility	51	Councils for Voluntary Service

5.6.1.2 Rating by own staff compared to rating by other staff

Table 34 Rating by own staff compared to rating by other staff for ensuring equitable access to health care

Organisation	Own staff	Other staff	Difference
Health Authority	86	83	+3
Local Authority	54	51	+3
NHS Trusts	71	78	-6
Primary Care Groups	83	79	+4
Councils for Voluntary Service	64	49	+15
Government Office North West	38	60	-22
NHS Executive North West	86	78	+8

5.7 Equity of access to resources

5.7.1 Tackling income inequality

Only Government Office North West was thought to have a high level of responsibility for tackling income inequality. Local Authorities were thought to have a moderate level of responsibility. All other organisations were thought to have a low level of responsibility.

Staff working for Government Office North West thought their organisation had 46% less responsibility in this area than did staff of other organisations. The potential for problems must be high, since other organisations will incorrectly expect Government Office North West to take lead responsibility in this area. Staff of Health Authorities and Local Authorities thought their own organisations had 11% and 9% more responsibility respectively than did staff in other organisations.

5.7.1.1 Responsibility

Table 35 Responsibility for tackling income inequality

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	71	Government Office North West
2	60	Local Authority
3	38	Councils for Voluntary Service
4	31	NHS Executive North West
5	27	Health Authority
6	25	Primary Care Groups
7 Least responsibility	20	NHS Trusts

5.7.1.2 Rating by own staff compared to rating by other staff

Table 36 Rating by own staff compared to rating by other staff for tackling income inequality

Organisation	Own staff	Other staff	Difference
Health Authority	37	26	+11*
Local Authority	68	59	+9*
NHS Trusts	15	22	-7
Primary Care Groups	26	25	+1
Councils for Voluntary Service	43	38	+5
Government Office North West	25	71	-46**
NHS Executive North West	41	30	+11

* Indicates that difference is statistically significant at the 5% level

** Indicates that difference is statistically significant at the 1% level

5.7.2 Helping ensure that public transport is affordable for people on low incomes

The Local Authorities followed by Government Office North West were considered the only two organisations to have high to moderate levels of responsibility for ensuring that public transport is affordable for people on low incomes.

Even though others perceived that they only had a low level of responsibility in this area, once again staff of Health Authorities thought their own organisations had 10% more responsibility than did staff of other organisations.

5.7.2.1 Responsibility

Table 37 Responsibility for ensuring that public transport is affordable for people on low incomes

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	76	Local Authority
2	67	Government Office North West
3	38	Councils for Voluntary Service
4	27	NHS Executive North West
5	22	Health Authority
5	22	Primary Care Groups
7 Least responsibility	15	NHS Trusts

5.7.2.2 Rating by own staff compared to rating by other staff

Table 38 Rating by own staff compared to rating by other staff for ensuring that public transport is affordable for people on low incomes

Organisation	Own staff	Other staff	Difference
Health Authority	31	21	+10*
Local Authority	69	77	-8*
NHS Trusts	11	16	-5
Primary Care Groups	20	23	-3
Councils for Voluntary Service	36	39	-3
Government Office North West	54	67	-13
NHS Executive North West	37	28	+9

* Indicates that difference is statistically significant at the 5% level

5.7.3 Helping ensure education and training are accessible to low-income and other vulnerable groups

The Local Authorities followed by Government Office North West were considered the only two organisations to have a comparatively high level of responsibility for ensuring that education and training are accessible to low-income and other vulnerable groups.

Although they were perceived by others to have a low level of responsibility in this area, once again staff of Health Authorities thought their own organisations had more responsibility (12%) than did staff of other organisations.

5.7.3.1 Responsibility

Table 39 Responsibility for ensuring that education and training are accessible to low-income and other vulnerable groups

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	79	Local Authority
2	71	Government Office North West
3	41	Councils for Voluntary Service
4	31	NHS Executive North West
4	31	Health Authority
6	29	Primary Care Groups
7 Least responsibility	22	NHS Trusts

5.7.3.2 Rating by own staff compared to rating by other staff

Table 40 Rating by own staff compared to rating by other staff for ensuring that education and training are accessible to low-income and other vulnerable groups

Organisation	Own staff	Other staff	Difference
Health Authority	41	29	+12*
Local Authority	80	79	+1
NHS Trusts	24	22	+2
Primary Care Groups	44	45	-1
Councils for Voluntary Service	53	44	+9
Government Office North West	68	72	-4
NHS Executive North West	45	30	+15

* Indicates that difference is statistically significant at the 5% level

5.8 Collaboration

5.8.1 Working with community groups to improve health

All organisations in the survey were thought to have a high or moderate level of responsibility to work with community groups to improve health, although there was little agreement about which organisation had most responsibility.

Although differences were small, Primary Care Groups may be expected to take the lead in this area as they were perceived to have the highest level of overall responsibility.



5.8.1.1 Responsibility

Table 41 Responsibility for working with community groups to improve health

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	80	Primary Care Groups
2	77	Health Authority
3	76	Local Authority
4	71	Councils for Voluntary Service
5	64	NHS Trusts
6	51	NHS Executive North West
7 Least responsibility	49	Government Office North West

5.8.1.2 Rating by own staff compared to rating by other staff

Table 42 Rating by own staff compared to rating by other staff for working with community groups to improve health

Organisation	Own staff	Other staff	Difference
Health Authority	77	77	0
Local Authority	78	75	+3
NHS Trusts	65	63	+2
Primary Care Groups	82	78	+4
Councils for Voluntary Service	77	70	+7
Government Office North West	14	50	-36
NHS Executive North West	57	51	+6

5.8.2 Working with other agencies to improve health

This is the only area where all organisations were thought to have a high level of responsibility.

5.8.2.1 Responsibility

Table 43 Responsibility for working with other agencies to improve health

Ranked position	Level of responsibility %	Organisation
1 Most responsibility	85	Health Authority
2	82	Local Authority
2	82	Primary Care Groups
4	76	NHS Trusts
4	76	NHS Executive North West
6	73	Government Office North West
7 Least responsibility	71	Councils for Voluntary Service

5.8.2.2 Rating by own staff compared to rating by other staff

Table 44 Rating by own staff compared to rating by other staff for working with other agencies to improve health

Organisation	Own staff	Other staff	Difference
Health Authority	84	85	-1
Local Authority	84	81	+3
NHS Trusts	78	76	+2
Primary Care Groups	85	81	+4
Councils for Voluntary Service	76	70	+6
Government Office North West	68	74	-6
NHS Executive North West	87	76	+11

5.9 Findings for responsibility for the determinants of health

Local Authorities were considered the organisation with the highest overall level of responsibility (an average score of 74%) for the 15 determinants of health studied. They were thought to have a high level of responsibility (i.e. more than 70%) in 12, and were rated the organisation with the most responsibility in 9 out of the 15 areas considered. The only areas where Local Authorities were not thought to have a high level of responsibility were 'equitable access to healthcare', 'tackling income inequality' and 'tackling psychological stress in the workplace', but then no organisation was thought to have a high level of responsibility for the latter.

Government Office North West was ranked as the organisation with the second highest level of overall responsibility (65%). Government Office North West had a high level of responsibility in areas less traditionally associated with health such as 'monitoring and addressing pollution'; 'ensuring that workplaces provide a safe environment'; 'tackling income inequality'; and 'working with other agencies to improve health'.

Health Authorities were ranked as the organisations with the third highest level of overall responsibility (57%). They had a high level of responsibility in areas traditionally associated with health such as 'encouraging healthy lifestyles in schools'; 'encouraging the public towards a healthier lifestyle', 'discouraging smoking and drugs'; 'ensuring equitable access to healthcare'; 'working with community groups' and 'working with other agencies to improve health'.

Primary Care Groups were ranked as the organisations with the fourth highest level of overall responsibility (52%). They had a high level of responsibility in a similar range of areas to the Health Authorities, such as 'encouraging the public towards a healthier lifestyle', 'discouraging smoking and drugs'; 'ensuring equitable access to healthcare'; and 'working with other agencies to improve health'. They were also considered the organisation with the highest level of responsibility for 'working with community groups' (80%).

NHS Executive North West was ranked as the organisation with the fifth highest level of overall responsibility (50%) and had a high level of responsibility in areas such as 'discouraging smoking and drugs'; 'ensuring equitable access to healthcare'; and 'working with other agencies to improve health'.

NHS Trusts were ranked as the organisations with the sixth highest level of overall responsibility (45%) and had a high level of responsibility in a similar range of areas to the NHS Executive North West even though their essential functions are different.

Councils for Voluntary Service were ranked just behind NHS Trusts as the organisation with the lowest level of overall responsibility (44%). They only had a high level of responsibility in areas such as 'working with community groups' and 'working with other agencies to improve health'.

5.9.1 Natural partnerships

All organisations were thought to have a high level of responsibility for 'working with other groups to improve health.' Conversely no organisation was thought to have a high level of responsibility for 'tackling psychological stress in the workplace'. For some areas there was an even gradient of level of responsibility ascribed to organisations (as described in the Tables.) For other areas, one or two organisations stood out and were thought to have a high level of responsibility, with other organisations having a much lower level of responsibility. For example, Local Authorities were thought to have a high level of responsibility (76%) for ensuring that 'public transport is affordable', closely followed by Government Office North West

(67%) with all other organisations considered to have a low level of responsibility i.e. less than 40%.

If these perceptions of responsibility are correct, they are indicative of a 'natural partnership' between Government Office North West and Local Authorities, since they had the two highest levels of responsibility for several areas such as 'monitoring and addressing pollution'; 'ensuring schools provide a safe environment'; 'ensuring workplaces provide a safe environment', 'ensuring that people are housed according to their needs'; 'tackling income inequality'; 'ensuring that public transport is affordable for people on low incomes'; 'ensuring that education and training are available for people on low incomes'; and 'promoting walking and cycling', although the Health Authority was considered to have as much responsibility for the latter as Government Office North West (64%).

Health Authorities and Local Authorities were thought to have the two highest levels of responsibility for 'promoting healthy lifestyles in schools' and 'working with other groups to improve health'.

5.9.2 Rating by own staff compared to rating by other staff

In many areas, Health Authority staff thought that the level of responsibility of Health Authorities was significantly higher than that perceived by staff from other organisations. This was particularly apparent in areas encompassing the wider determinants of health that fall outside the traditional realm of health services. Health Authorities should expect to experience problems when forming partnerships or working with other organisations on projects outside their traditional area of responsibility and expertise since many staff working for other organisations did not think Health Authorities had much responsibility in these areas.

Local Authority staff rated the responsibility of Local Authorities very closely to that given by staff from other organisations in most areas. Local Authority staff thought their organisations held 9% more responsibility for 'tackling income inequality' and 8% less responsibility for 'helping ensure that public transport is affordable for people on low incomes'. These two differences were statistically significant.

NHS Trust staff thought that the level of responsibility of NHS Trusts was lower in 11 out of 15 areas, although the difference was only statistically significant in the area of 'promoting healthy lifestyles in schools'. There appeared to be less agreement about the level of responsibility of the Council for Voluntary Service. Councils for Voluntary Service staff thought that the level of responsibility of their organisation was higher in 9 and lower in 5 of the 15 areas. Variation appeared quite marked from 10% lower for 'promoting walking and cycling' to 19% higher for 'encouraging healthy lifestyles', but no differences were statistically significant.

The greatest difference of opinion between rating by own staff compared to rating by other staff came from Government Office North West. Government Office North West staff thought that the level of responsibility of their organisation was lower in 14 out of the 15 areas examined. The differences ranged from between 3% higher to 53% lower and despite the small sample size were statistically significantly lower in the areas of 'discouraging smoking'; 'tackling income inequalities' and 'ensuring schools provide a safe environment'.

Staff from NHS Executive North West also demonstrated great variation between rating given by own staff compared to rating by other staff. NHS Executive North West staff thought that the organisation's level of responsibility was higher in 12 and lower in only 1 of the 15 areas included in the study. The differences ranged from between 34% higher to just 2% lower and again despite the small sample size were statistically significantly higher in the areas of 'ensuring work places provide a safe

environment', 'ensuring that people are housed according to need' and 'addressing pollution'.

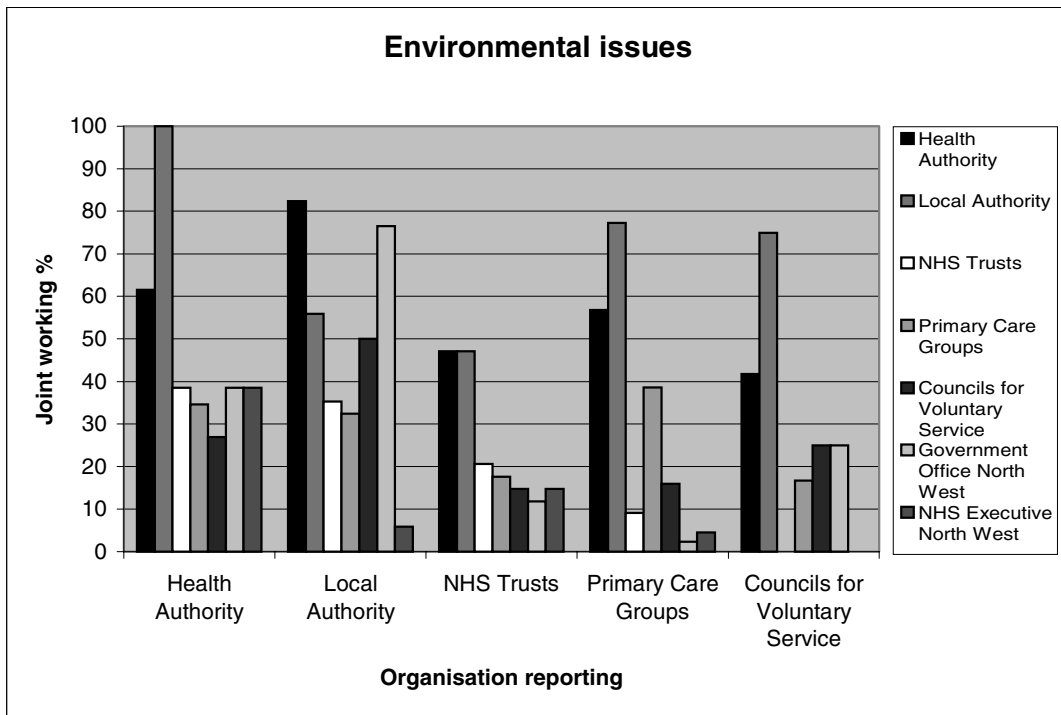
5.9.3 Difference of opinion between staff

Analysis using Kendall's coefficient of concordance showed that between all four bigger organisations, there was a high degree of agreement about the ranking of organisations for level of responsibility for determinants of public health studied ($P < 0.001$ in every case). There was slightly less highly statistically significant agreement between groups of workers within organisations or between staff of Councils for Voluntary Service. Again however, the results for Councils for Voluntary Service may be affected by the smaller number of respondents involved. Due to the small numbers of individuals involved, results from the staff of Government Office North West and NHS Executive North West were excluded from this analysis.

5.10 Joint working

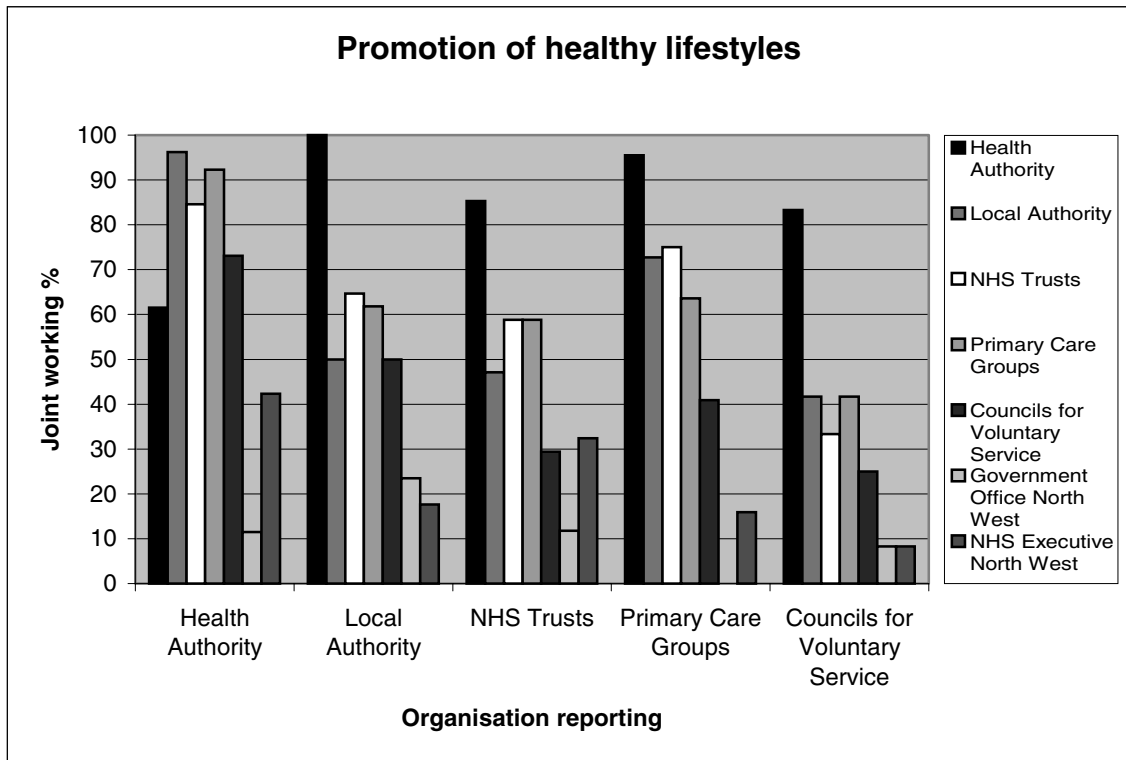
The charts and Table below show the percent of respondents in each organisation that reported that they or their organisation worked jointly with the other organisations included in the study. The charts show the level of joint working reported by the five larger organisations. Data from staff of Government Office North West and NHS Executive North West were excluded because of the small number of respondents reporting, but data on joint working with these organisations from staff in other organisations were included.

Figure 2 Joint working on environmental issues



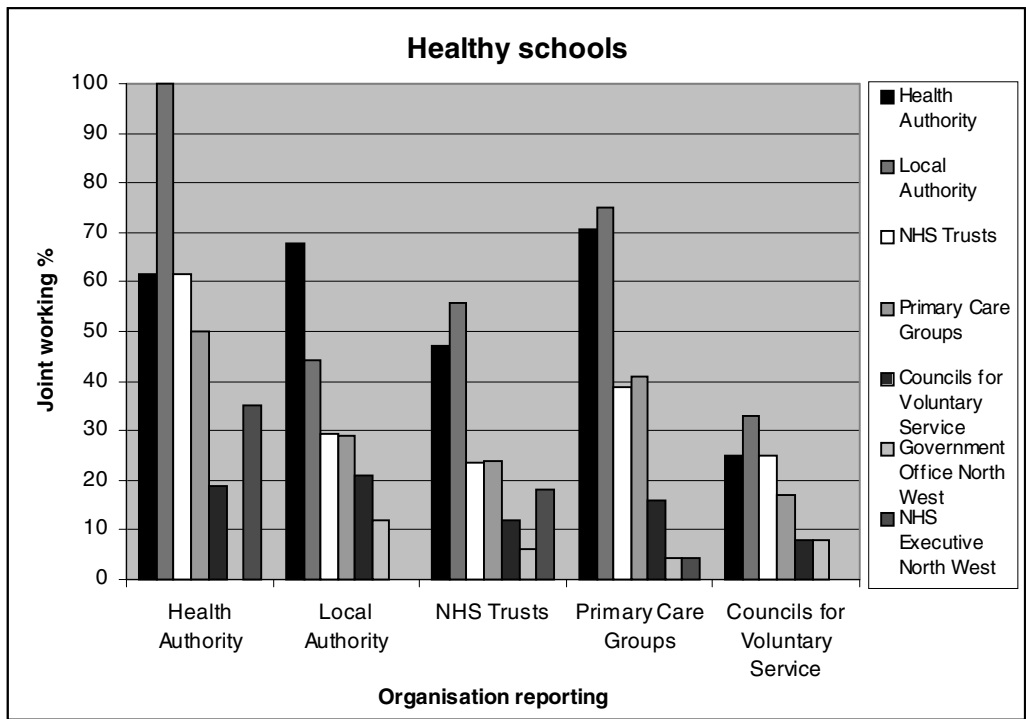
Local Authorities were the organisation most commonly worked with on environmental issues. All Health Authority staff reported joint working with Local Authorities, while only 82% of Local Authority staff reported joint working with Health Authorities. Overall Health Authorities and Local Authorities reported the highest levels of joint working (an average of 48% across all potential partners). This was closely followed by Government Office North West and NHS Executive North West (43%).

Figure 3 Joint working on promoting healthy lifestyles



Staff from Health Authorities, Local Authorities and Primary Care Groups all reported an average level of more than 50% of joint working across all organisations. Health Authorities were the organisation most commonly worked with on the promotion of healthy lifestyles.

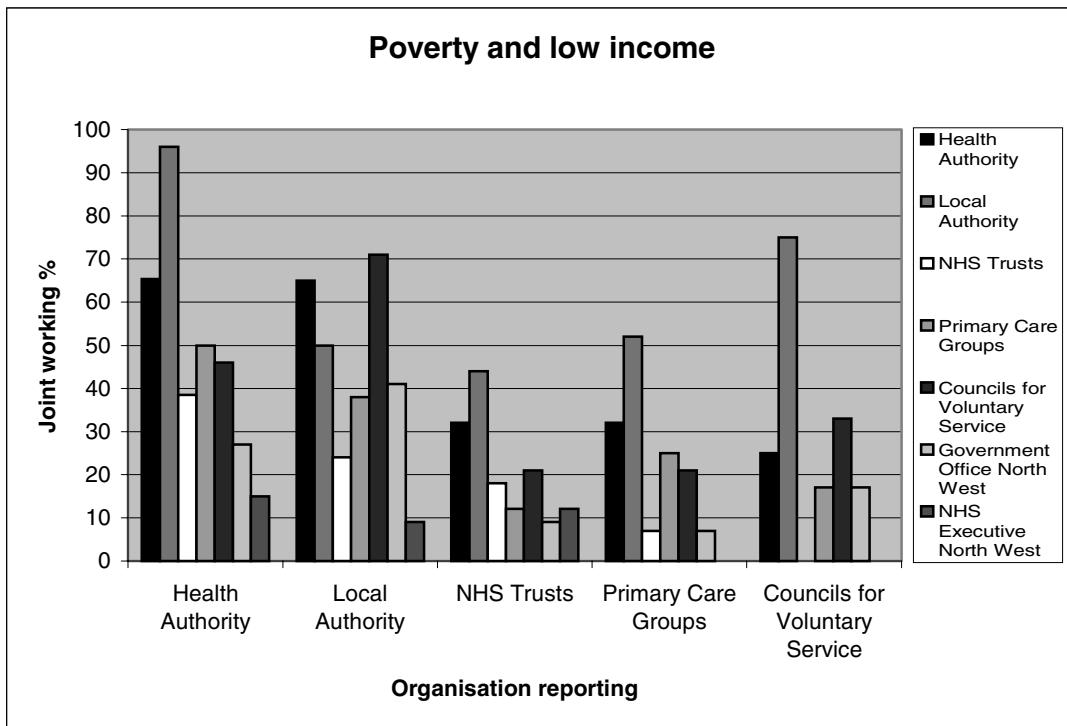
Figure 4 Joint working on healthy schools



Staff from no organisation reported an average level of more than 50% joint working across all organisations in this field. Health Authorities and Primary Care Groups reported the highest levels of joint working (47% and 36% respectively). 100% of Health Authority staff reported joint working with Local Authorities, but only 68% of Local Authority staff reported joint working with Health Authorities in this field.

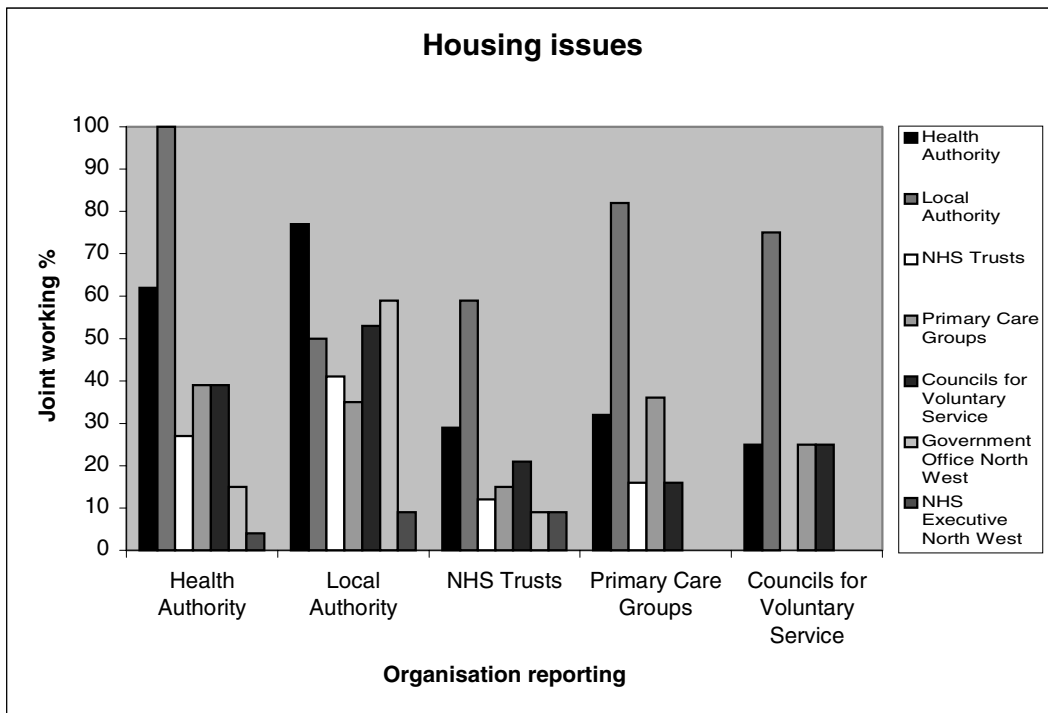


Figure 5 Joint working on poverty and low income



Again, staff from no organisation reported an average level of more than 50% joint working across all organisations in this field. Staff from Health Authorities reported the highest levels of joint working (48%), followed by Local Authorities (43%) Health Authority staff reported very high levels of joint working with Local Authorities (96%) but only 65% reported vice versa.

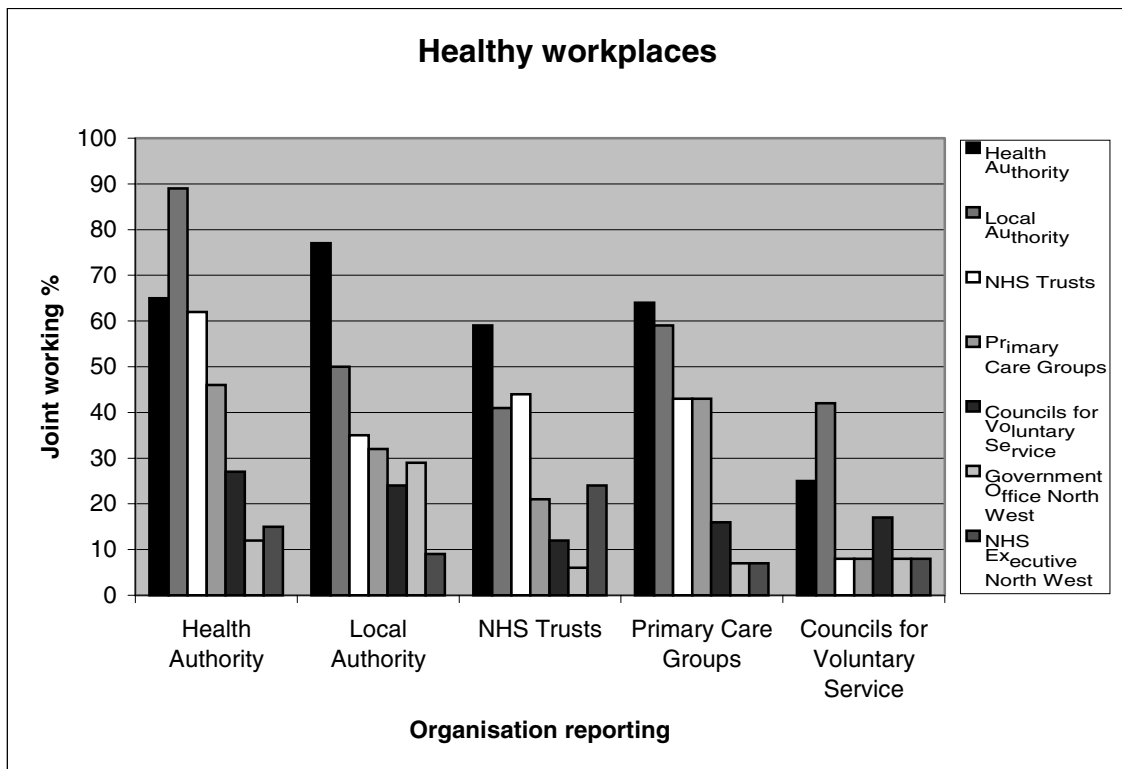
Figure 6 Joint working on housing issues



Again, staff from no organisation reported an average level of more than 50% joint working across all organisations in this field. Staff from Local Authorities reported the highest level of joint working (46%) followed by Health Authorities (41%). All Health Authority staff (100%) reported joint working with Local Authorities, but only 77% reported vice versa.



Figure 7 Joint working on healthy workplaces



Staff from Health Authorities reported the highest level of joint working across all organisations (45%.) followed by staff from Local Authorities (37%.) Primary Care Groups (34%) and NHS Trusts (30%)

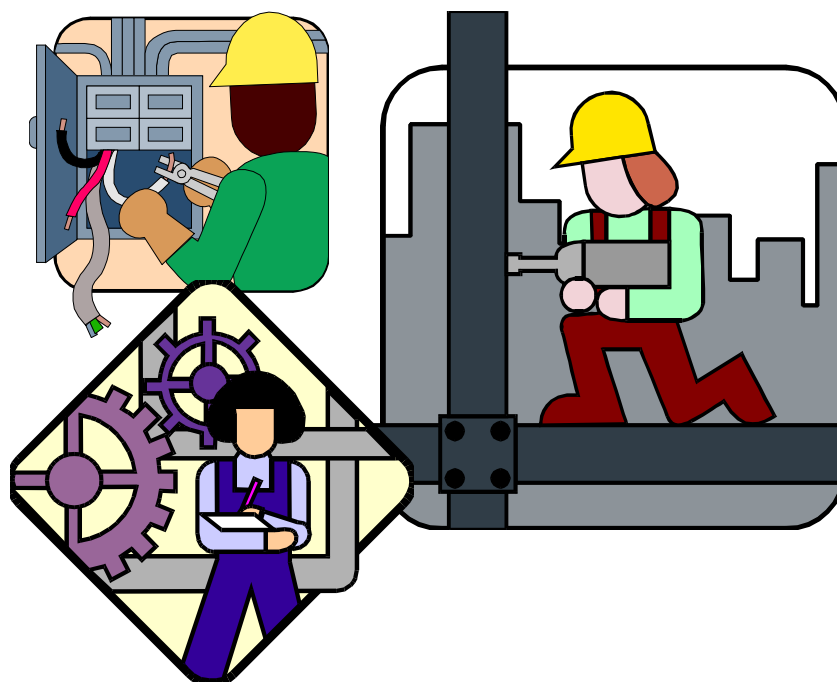
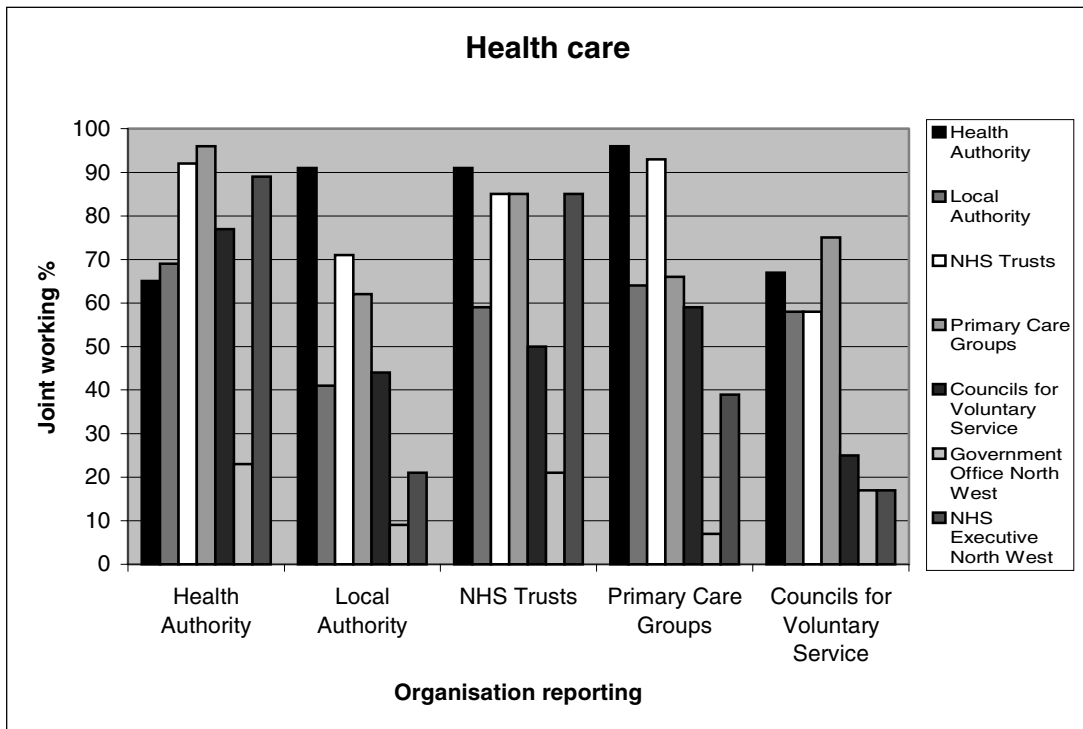


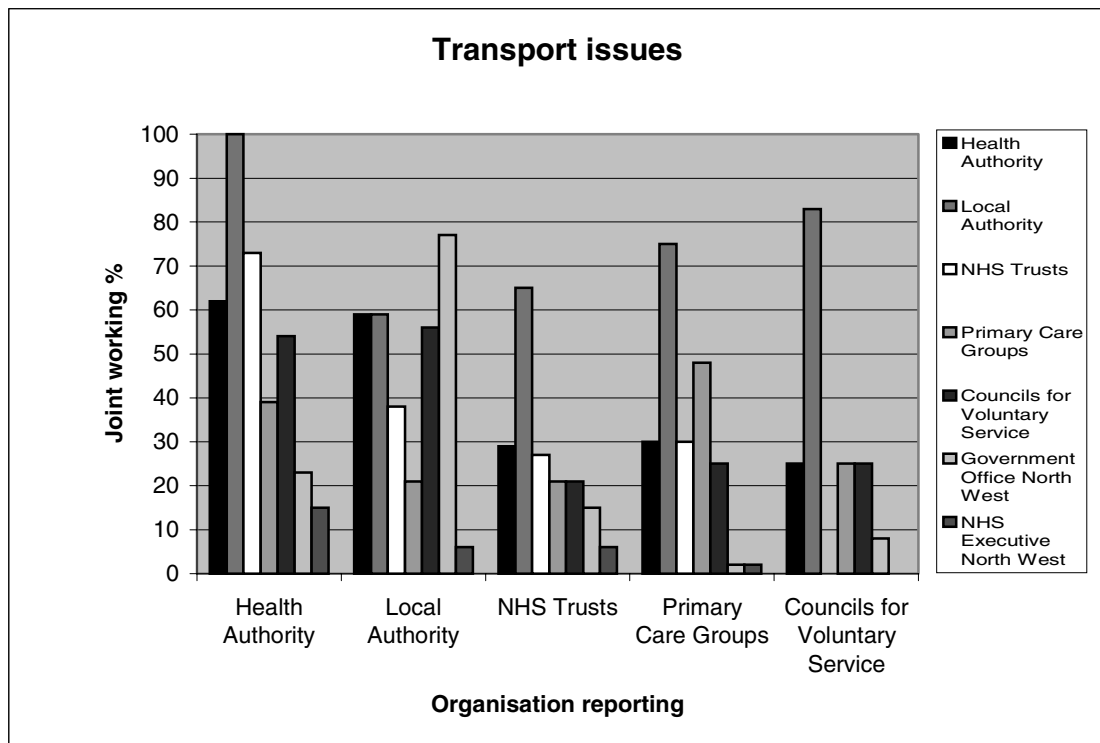
Figure 8 Joint working on health care



Staff from four organisations reported an average level of joint working of over 50% across all organisations in this field. Staff from Health Authorities reported the highest level of joint working (73%) followed by NHS Trusts (68%) Primary Care Groups (61%) Local Authorities (48%) and Councils for Voluntary Service (45%).



Figure 9 Joint working on transport issues



Only staff from Health Authorities reported an average level of more than 50% joint working across all organisations, closely followed by Local Authorities (45%). All (100%) of Health Authority staff reported joint working with Local Authorities but only 59% reported vice versa. Only 59% of Local Authority staff reported joint working with another Local Authority.



Table 45 Average levels of joint working across all potential partners by each organisation

Organisation*	Health Authority %	Local Authority %	NHS Trusts %	Primary Care Groups %	Council for Voluntary Service %	Government Office North West %	NHS Executive North West %
Area of work							
Environmental issues	48	48	25	29	26	43	43
Promotion of healthy lifestyle	66	53	46	52	35	36	71
Healthy Schools	47	29	27	36	17	29	38
Poverty and low income	48	43	21	21	24	36	48
Housing issues	41	46	22	26	21	36	48
Healthy workplaces	45	37	30	34	17	7	76
Health care	73	48	68	61	45	7	81
Transport issues	52	45	26	30	24	36	43
<i>Overall Average</i>	<i>47</i>	<i>39</i>	<i>29</i>	<i>32</i>	<i>23</i>	<i>26</i>	<i>50</i>

*For each organisation, figures represent the average reported level of joint working with all other organisations for each area of work. The overall average is the mean level of joint working across all areas of work.

5.11 Findings for joint working

Reported joint working by staff from Health Authorities with Local Authorities was the highest of any two organisations. Between 89% and 100% of Health Authority staff reported that they or their organisation worked with the Local Authority in every area studied (apart from health care where only 69% of staff reported joint working.) However the reverse was not true, with Local Authority staff far less likely to report joint working with Health Authorities.

Overall NHS Executive North West reported the highest average level of joint working, but numbers of staff reporting were very low.

Staff from Councils for Voluntary Service reported the lowest average levels of joint working followed by NHS Trust staff. However, staff from Councils for Voluntary Service reported high levels of joint working with specific organisations in particular areas. Three quarters (75%) of Councils for Voluntary Service staff reported working with the Local Authorities in the areas of 'environmental issues', 'poverty and low income' and 'housing issues'; and 83% in the area of 'transport issues'. Three quarters (75%) of Councils for Voluntary Service staff reported working with Primary Care Groups in the area of 'health care' and 83% reported working with Health Authorities on the 'promotion of healthy lifestyles'.

Local Authorities were reported as the organisation most commonly worked with overall, closely followed by Health Authorities. Councils for Voluntary Service, Government Office North West and NHS Executive North West were mentioned least often, but as they are smaller organisations, no conclusions should be drawn from this.

The prevalence of joint working with 'sister' organisations that exist at multiple sites was interestingly low. Only 56% of Local Authority staff reported working with other Local Authorities on topics that must cross several Local Authority boundaries such as environmental issues and 59% on transport issues. Similarly only 25% of Primary Care Group staff reported working jointly with other Primary Care Groups in fields that cross Primary Care Group boundaries such as poverty and low income and only 48% on transport issues.

The highest degree of joint working across all organisations was reported in the area of health care closely followed by healthy lifestyles, with all other areas equally matched further behind.

6 Discussion

6.1.1 Determinants of health

Box 5 Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

Improvements in health require a secure foundation in these basic prerequisites.

Ottawa Charter for Health Promotion (1986)²⁰

As this quotation from the Ottawa Charter shows, it has been known for several years that the basic prerequisites for health fall largely outside the realm of health organisations. Whoever controls these prerequisites through public policy or other politics has most responsibility for determining health.

In a recent article in the British Medical Journal, Sally Macintyre reinforced this idea by saying that 'The major drivers of health and the distribution of health lie outside the health service²¹'.

This study found that Local Authorities and Government Office North West, two organisations of local Government were considered to have most responsibility for, and therefore most influence over the wider determinants of health. Health Authorities had most responsibility in areas of health promotion relating to personal lifestyle, and health care.

At the time of the study, (August 1999) Primary Care Groups had only recently been formed, (April 1999) and the findings that they were considered to have similar, though slightly lower levels of responsibility than Health Authorities might reflect a degree of uncertainty about their specific levels of responsibility. The high level of responsibility attributed to Primary Care Groups for 'working with community groups' demonstrates an understanding and high expectation of their community focused role.

The reported high level of competency required by all organisations studied demonstrates the perceived need for public health skills in all organisations.

6.1.2 Joint working

The findings delineate the areas where two or more organisations have a high degree of responsibility. A high level of joint working in these 'common' areas was expected and in general was found. For example, 'promotion of healthy lifestyles in schools' and 'encouraging the public towards healthier lifestyles' were two areas where both the Health Authority and the Local Authority had high levels of responsibility. 'The promotion of healthy lifestyles' was an area where 100% of Local Authority staff and 96% of Health Authority staff reported joint working with the other

organisation. Only Government Office North West and Local Authorities were thought to have a high level of responsibility for 'addressing pollution'; and 'environmental issues' was an area where 77% of Local Authority and 100% of Government Office North West staff reported joint working with the other organisation. A similar picture emerged in relation to responsibility for, and joint working on transport. Possibly for reasons mentioned later, levels of joint working with Government Office North West and NHS Executive North West were lower than for other organisations. The highest level of joint working recorded for any organisation working with Government Office North West was 77%.

Information about joint working in the areas where Councils for Voluntary Service had a high degree of responsibility, such as 'working with other groups and communities to improve health' was not specifically requested, but a high degree of joint working (83%) was reported with Health Authorities in the area of 'promotion of healthy lifestyles'.

There were several areas where more staff reported working with another organisation than vice-versa. There are several possible explanations for this apparent discrepancy.

- Different interpretations of the meaning of 'joint working.' Staff from some organisations may be under considerable pressure to work jointly and as they want to appear to be following Government directives, will be more likely to label what they do as 'joint working'.
- Senior staff who completed the questionnaires may be under the mistaken impression that more or less 'joint working' is going on than is really the case.
- More staff in one organisation than in the other being aware of the joint working that is taking place.
- There is only one Government Office North West and one NHS Executive North West office, but there are many Local Authorities, Health Authorities, NHS Trusts and even more Primary Care Groups. It may be possible that all staff at Government Office North West reported working with Health Authorities, because they do work jointly with one or more but possibly not all Health Authorities, so fewer staff from Health Authorities reported working with Government Office North West than vice versa.
- Similarly it may be possible that whereas all Health Authority staff reported working jointly with a Local Authority, the reverse may not necessarily be true. There is no information about which Local Authority the Health Authority staff worked with. Since both organisations have responsibility for a geographical area, it would seem likely that in general each organisation worked with the partner organisation in the area.

Scrutiny of the reported joint working between Health Authorities and Local Authorities helps to shed some light on the noted anomalies. In the area of 'health care,' an area traditionally regarded as the responsibility of Health Authorities, 91% of Local Authority staff said that they worked with a Health Authority, yet only 69% of Health Authority staff reported joint working with a Local Authority. As expected, Health Authorities were thought to have the highest level (84%) of responsibility for equity of access to health care. The reverse was true in the area of transport – a more traditional Local Authority responsibility. Local Authorities were reported to have the highest level of responsibility (76%) for ensuring transport is affordable. All (100%) of Health Authority staff reported joint working with a Local Authority, but only 59% of Local Authority staff reported joint working with a Health Authority on transport issues. The White Paper 'A New Deal for Transport: Better for Everyone'²²

clearly indicated the need for partnership working and for public health to be considered in the development of Local Transport Plans.

These results seem to indicate either a reluctance or an inability to recognise the role or responsibility of partner organisations in areas where one organisation has traditionally taken lead responsibility.

Health Authority staff appeared to have a good understanding of the broader determinants of health when they reported that Health Authorities should have a high degree of responsibility for non traditional health service matters, such as pollution, housing, poverty, transport, education and training. However, other organisations did not recognise the Health Authority's high level of responsibility in these areas. This difference in understanding of roles and responsibilities will inevitably lead to problems with partnership working in these areas.

The Health Act 1999⁴ provides the legislative authority for joint working on the broader determinants of health. See Box 6.

More than legislation will be needed to achieve partnership working between organisations that demonstrate such different perceptions of each other's roles and responsibilities.

Box 6 The Health Act

'In exercising their respective functions, NHS bodies (on the one hand) and Local Authorities (on the other) shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.'

The Health Act 1999⁴

Responsibility for environmental issues such as 'monitoring and addressing pollution' rested predominantly with Local Authorities, (84% compared to only 45% for Health Authorities) but more Local Authority staff reported joint working with Health Authorities (82%) than with other Local Authorities (56%) on environmental issues. Reported joint working on environmental issues between the Local Authority staff and Government Office North West – the regional organisation was 77%.

This lack of joint working with the same organisation at a different site was apparent throughout. For example, Health Authorities were considered the organisations with most responsibility for 'ensuring equity of access to health care' (84%), yet only 65% of Health Authority staff reported joint working with another Health Authority compared to 69% with a Local Authority and 89% with NHS Executive North West in the field of 'health care'. Health Authorities were considered to have the most responsibility for 'encouraging healthy lifestyles' (78%) yet only 62% of Health Authority staff reported joint working with another Health Authority, and even fewer, 42% with NHS Executive North West, but 96% worked with a Local Authority. This indicates that organisations are more likely to work jointly with other organisations in the local area more than they are to work, either with counterparts in a similar organisation from another area, or through a regional organisation such as Government Office North West or NHS Executive North West.

Joint working between Health Authorities and Local Authorities on strategic planning, service commissioning and provision is a Government requirement⁴ and underpins local health improvement as well as other programmes and the Health Action Zones. Thus, a high level of joint working between these organisations would be expected and was found. The lack of joint working between the same organisations from different areas might be an artefact of reporting. Alternatively, it may indicate either a lack of opportunity for the sharing of best practice or an unwillingness or lack of

ability to work jointly. Without joint working within as well as across organisations there will be unnecessary duplication of activities and developments and the far-reaching benefits to the public of partnership between organisations will not be realised.

Extensive joint working between district level and regional organisations in any area other than 'health care' was not reported, suggesting that regional organisations may not be acting as co-ordinators for work on wider determinants of health. Joint working reported by staff from Health Authorities with NHS Executive North West was only 32% on average across all areas included in the study.

7 Conclusions

7.1.1 Mismatch of responsibility and skills

The main conclusion from this study must be that most responsibility for many of the issues that affect public health lies with Local Authorities and Government Office, but that most competency in public health skills lies with Health Authorities and NHS Executive. The mediocre levels of competency for purpose reported across the board clearly demonstrate the need for increased capability in public health skills in all organisations included in the study. This is especially true for Local Authorities and Government Office North West who were attributed with the highest level of responsibility in many public health areas; but who on average were thought to possess only 57% and 48% respectively of the competency required in the five major public health skills reported in this study.

The Government's public health strategy can only be fulfilled if the right skills are in the right place at the right time. If not attended to, this current mismatch of skills and responsibilities for public health will seriously detract from the ability to deliver the required public health outcomes outlined in 'Saving Lives: Our Healthier Nation'⁹ and other Government papers.

7.1.2 All organisations are stakeholders

For many of the areas investigated in the study, one or two organisations were thought to hold high levels of responsibility; but all organisations were thought to hold at least some responsibility in every area. The implication of this finding is that all the organisations should be regarded as stakeholders and included in partnership plans.

Lack of partnership skills and the apparent reluctance to work together demonstrated by organisations that have different levels of responsibility will seriously detract from the ability of organisations to harness the public health potential in the community.

7.1.3 Keep public health high on the agenda

Public health is high on the agenda of many organisations. A healthy population is a valuable resource for economic development. A healthy workforce suffers less absenteeism, requires less payment of benefits and has higher levels of productivity. 'Efforts to create opportunities for employment and to strengthen business in the North West will founder without a healthy and skilled population.'²³ The Regional Development Agency as the co-ordinator of development and involved with many organisations in the North West Region needs to keep public health at the centre of its strategy for economic development and regeneration. Public health and economic regeneration are closely linked and should be mutually supportive.

7.1.4 Misunderstanding of roles and responsibilities

Although the study found extensive reports of joint working there was also evidence of misunderstanding and disagreement between organisations about what constitutes joint working; levels of responsibility between different organisations; and who should be involved with what issues. A basic tenet for partnership working is good communication and a clear understanding of roles and responsibilities.¹⁵ The findings from this study demonstrate the need for better communication especially in relation to clarification of roles and responsibilities of organisations.

Government has made legislative changes to make joint working easier.^{2, 4} Health Improvement programmes and Joint Investment Plans with pooled budgets, lead commissioning and integrated provision are all available. 'Ministers believe that The Health Act 1999 removed the last legislative impediments to their dream of joined-up service provision'.²⁴ It is up to Local and Health Authorities to decide arrangements for joint working, but the facilities provided through legislation cannot be used effectively until there is better understanding of roles and responsibilities within and between organisations. Some of the most poignant failures of joint working in the past resulted in the tragic abuse and deaths of children.² Better partnership working will reduce the risk of a repetition of similar tragedies. Julia Hiscock and Maggie Pearson argue that although Government is pressing for collaboration, and that legislative changes have made joint working possible, 'cultural and professional gaps' between organisations are widening and deteriorating due to 'preoccupations with changes within their own organisations and daily work'.²⁵ The misunderstanding of roles, responsibilities and skills held between organisations found by this study must contribute to these 'cultural gaps' and reduce the ability of organisations to provide the quality of service needed. It is not enough to attempt to force organisations into reluctant partnerships through legislation. Without accompanying supportive training and management to break down the cultural barriers, effective partnerships will remain a pipe dream of Government and the seamless services we all deserve will not be realised.

Government's wishes could not be clearer. The section on Modernising Public Services in the Modernising Government White Paper²⁶ says that 'Modern Government means making sure that citizens and businesses come first ... We want to provide public services that respond to users needs and are not arranged for the providers convenience.' The recently published National Service Frameworks say that 'Delivering the National Service Framework (for mental health) will require new patterns of local partnership, with mental health a cross cutting priority for all NHS and social care organisations and their partners'.²⁷ Without the building blocks of good communication and a common understanding of roles and responsibilities, the ability of organisations to achieve these standards is questionable.

That barriers to 'joining up' do exist and need to be removed has been recognised by Government. The Cabinet Office report 'Wiring it up'⁵ goes on to say that 'badly handled, cross cutting issues can undermine the effectiveness and value for money of Government policies ... The skills and capacity to develop and deliver cross-cutting solutions are often absent ... More civil servants should be given immediate practical experience of handling conflicts of interest and complex reporting lines of genuine partnership working.'

Interestingly the two Regional organisations were at opposite ends of the spectrum of misunderstanding of responsibilities. Government Office North West staff felt that its organisations had a lower average level of responsibility and conversely NHS Executive North West staff thought that its organisation had a higher level of responsibility than did staff from other organisations. This supports the conclusions of the interim report of a project to strengthen the public health function of England²⁸,

which found that a wider understanding of health and better co-ordination of activities was required and that there was a need to increase capacity and capability and to strengthen joint working in Government, particularly at Regional level.

Staff working in an organisation want to feel that their organisation is performing well, so it was not unexpected to find that most staff thought that their organisation was more skilled than others perceived it to be. From this study alone, it is impossible to know whose perceptions are most correct – the staff of the organisation, in which case they need to publicise what they are doing more clearly to others; or the staff of the other organisations, in which case performance needs to be improved. Whichever is correct, communication needs to be improved.

Although Health Authorities, Local Authorities, NHS Trusts, Primary Care Groups and Councils for Voluntary Service all have clearly defined geographical boundaries and are primarily responsible to the people living in their area, the lack of joint working with neither organisations of the same type nor regional organisations especially in areas such as pollution and transport whose problems cross geographical boundaries suggests a degree of parochialism.

Many problems across the Region must have similar aetiologies; and to have people in different offices across the Region working independently on the same issues cannot fail to be inefficient.

8 Recommendations

Some of these recommendations may already be taking place or are being planned, but putting them here serves to reinforce their need.

- 1) Publicise the growing need for public health training and expertise (including the ability to work in partnership) throughout all organisations that are connected to public health.
 - * Make senior managers of organisations aware of the need to increase public health capacity in order to implement current Government strategy. This is possibly a role that could be taken on by Government Office North West and the NHS Executive North West in their Regional co-ordinating capacities. A role encouraged by Government.⁶
 - * Make senior staff of the Regional Development Agency and other Regional organisations aware of the constraints to Regional development that will occur if public health is neglected in development plans.
 - * Make senior managers of all relevant organisations more aware of the importance of multi-sectoral partnership working and the added value that other organisations might be able to bring to a partnership situation.
- 2) Increase and improve training in forming and working in partnerships for all staff working in public health.
 - * Organisations to work together to develop proper partnership criteria that would include channels for communication. This is possibly another role that could be taken on by Government Office North West and the NHS Executive North West in their Regional co-ordinating capacities.

- 3) Improve the public health skills, including the ability to develop and work in partnerships, of staff in all organisations with a responsibility for the broader determinants of health, but particularly Local Authorities, Government Office and community level organisations
- * Increase the in-service training of Local Authority staff. This can be achieved by increasing the capacity of local courses.^c These courses provide the public health skills needed by non health service professionals, and are already available in the Region.
 - * Provide more flexible public health training courses with distance learning modules, so that staff unable to attend the training centre can still benefit.
 - * Increase the number of public health professionals working in local Government and other local organisations either through more joint working with public health professionals in Health Authorities or secondment of public health trained staff to Local Authorities and other organisations. For instance, Health Authorities could help their Primary Care Groups develop public health approaches and programmes.
 - * Make a basic level of training in public health skills an essential requirement for those Local Authority posts with a responsibility for the broader cross - cutting issues that determine health. In service public health training could be offered to staff already in post that do not possess the required public health skills.
 - * Increase the number of staff in the workforce with recognised public health skills in each organisation.
 - * Develop a public health mindset in all public service organisations.
 - * Identify successful innovative practice both inside and outside Government organisations and use the experience and expertise developed to help other organisations improve their practice. Organisations could become 'beacons' for joint working or public health practice. This is particularly relevant for partnership working situations.
- 4) Allocate sufficient resources to endorse recommendation 3 above.
- * Allocate money from the public health development fund to 'pump prime' training initiatives in a wide range of organisations, until such time as organisations can sustain public health training from their own budgets.
 - * Provide increased funding to Universities to expand the availability of public health training. Increase the numbers of places available on the Masters degree in Public Health, the 'Sokrates' and other programmes.
 - * Make use of the ability to pool Health Authority and Local Authority budgets to remove the barrier of lack of funding for the public health training of non – health professionals.

^c One example is the 'Sokrates' programme run from the public health sector of Liverpool John Moores University (<http://www.phpu.org.uk>). This programme is designed primarily to provide public health skills to people working in a variety of situations, especially those in non traditional health settings.

- 5) Encourage further research to discover the reasons for the anomalies found by this study such as the different levels of joint working reported by different organisations.
 - * Carry out a qualitative piece of work to look in more depth at what people mean by 'joint working' and elucidate the major barriers to partnership working.
 - * Implement pilot partnership projects and analyse their effectiveness to help determine best practice in terms of partnership working for public health.
- 6) Increase communication between all organisations involved with public health, so that each can better understand what the others are doing.
 - * Ensure that the clarified positions, wider public health roles and responsibilities of organisations are communicated to and understood by all other relevant organisations. This should encourage understanding of the benefits of partnership working and help overcome traditional barriers to joint working.
 - * Organise regular multi-sectoral gatherings or other form of communication for the discussion of roles and responsibilities. This might be a role best taken on by NHS Executive North West Regional Office or Government Office North West .
 - * Continue efforts to make geographical boundaries for Local Authorities, Primary Care Groups, Health Authorities etc co-terminous to facilitate communication between organisations.
- 7) Make explicit the complementary nature of the responsibilities for the broader determinants of health in all organisations, but especially between Local Authorities and regional organisations in order to prevent confusion, avoid problems with joint working and encourage the development of effective partnerships.
 - * Encourage senior staff of all organisations but particularly Local Authorities (since they hold the highest level of responsibility for the determinants of public health) to recognise the health impact of their policies and practices and acknowledge the need for joint working where appropriate.
 - * Encourage all organisations to carry out health and / or integrated impact assessments on all new policies, any major policy modifications and all new development projects to increase awareness of the relationship between development and health and use this as the basis for building partnerships.
- 8) Continue work to change the insular culture of organisations.
 - * Explicit management efforts to change the bureaucratic nature of public organisations.
 - * Provide management training to help staff cope with the constant changes.
 - * Work to make staff feel more secure in their own jobs, so that they can go out confidently and form partnerships without feeling threatened.
- 9) Encourage joint working across geographical boundaries where this would be beneficial to public health – such as monitoring and dealing with pollution and transport.
 - * Increase the level of joint working particularly with the regional organisations and strengthen their role in providing strategic leadership and co-ordination.

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