Leading together better

Final report for the IDeA
by Shared Intelligence

part of the **LGA group**

Acknowledgements

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Contents

1.0 Foreword

This seems a particularly opportune moment to explore the working relationship between key local authority directors and to reflect on the strength of partnership working locally. With a forthcoming General Election and Sir Michael Marmot set to report on the future approach to tackling health inequalities our focus needs to be on how collaboration can be improved and how other key strategic partners can be better engaged in improving health.

It is heartening that this publication reflects a positive picture of partnership working to improve health outcomes and well established local relationships. It's also very encouraging to see the joint working at a national level between the three Associations to take this report forward. The Improvement and Development Agency (IDeA) is very happy to support and facilitate these activities.

The report does present some challenges however, which are summed up in the key questions posed at the start of the document. I hope that this report provides a basis for local discussion, particularly at a time when those advocating the long term preventative agenda may be struggling to be heard.

Our next steps are to listen to your feedback and to then decide how as national organisations we can best support better partnership outcomes locally.

Andrew Cozens
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2.0 Executive summary

Why read this report?

This report is designed to explore and support effective working to tackle health inequalities, primarily between the three local directors with some named responsibility (directors of adults' services, children's services and public health) and to promote a discussion, among members and officers, about the role of other council and public services in promoting health and tackling health inequalities. The report raises five key questions which demonstrate the value of this publication in our current political and economic climate:

- How are joint appointments and integrated working being used to best effect?
- How can they be improved further to meet expected budget shortfalls?
- How are a range of council services and partners being engaged in tackling the wider social determinants of health and taking preventative action upstream?
- How can an understanding of what 'good' looks like, with regard to joint appointments and partnership working for health and wellbeing be developed?
- How can this be developed to support the achievement of corporate priorities and effective outcomes for communities?

The Improvement and Development Agency and the professional associations involved (Association of Directors of Public Health (ADPH), Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS) are keen to hear your views on these questions and what actions they can take to further the debate on the issues raised in the report.

The IDeA is supporting the project via its Communities of Practice. A discussion forum is being run on the Healthy Communities Community of Practice (CoP) as a space to share your thoughts with other colleagues. To register for the CoP, visit www.communities.idea.gov.uk and search for 'healthy communities'.

Key messages

- The three directors should jointly lead the health and wellbeing agenda locally.
- The tripartite relationship is important and a strength where it is working well.
- The independent role of the Director of Public Health (DPH) can be important in gaining credibility and influence across organisations and with elected members.
- Elected members play a vital role in promoting the health and wellbeing agenda and a strong DPH / lead member relationship is important.
- Tackling the wider social determinants of health and wellbeing remains key to success, particularly with health inequalities. Support for engaging the wider stakeholders would be of enormous value.
- Joint DPH appointments are 'a good thing', but more could be done to promote the drivers and manage the barriers.
- There needs to be widespread understanding of what success looks like for joint appointments, partnership working and for health and wellbeing processes and programmes.

Introduction

This research exercise into joint working between directors of public health (DsPH), directors of adults' services (DsASS) and directors of children's services (DsCS) took place in May and June 2009. The aims of the project were to explore the appetite for joint working; establish what current arrangements exist; and find out what opportunities for joint development are currently provided and what future support would be useful.

The impetus for this exercise came from the joint ADASS, ADCS and ADPH conference in 2008, at which the subject of joint development for DsASS, DsCS and DsPH was raised.

Local-level appetite and current arrangements

The study revealed a strong appetite for and commitment to joint working at a local level, and a clear recognition of the health agenda as a cross-cutting issue. Joint working between the three posts was revealed to be routine and there was an increasing realisation of its importance to the health agenda. The tripartite arrangements (between the three directors) varied considerably, but there was an acceptance that the relationship is vital for effective outcomes.

In fact, there was a widely held view that the tripartite relationship, although important and in some places needing development, should be seen within the context of the wider strategic workforce. Ensuring the inclusion of other key stakeholders whose remit covers the wider social determinants (for example, spatial planning and the police) as well as elected members in planning for the delivery of health and wellbeing outcomes, was seen as just as important and often in need of more support.

Benefits of joint working

Significant benefits from joint working were perceived, including better outcomes, more effective prioritisation, improved efficiency, developing new skills sets and shared accountability.

Joint strategic needs assessments (JSNAs) have been a major driver for joint working, with a stronger evidence base supporting the development of clearer joint priorities.

The DCS, DASS and DPH relationship was seen as being particularly important in terms of transition planning, safeguarding and emergency planning (for example, swine flu).

Most interviewees understood joint working in a wider partnership context (whole senior management team(s) and/or the local strategic partnership (LSP)) and that was where both the real organisational and delivery benefits were derived and a focus on wider health and wellbeing outcomes achieved.

DsPH found working with elected members a particularly useful aspect of close joint working with the local authority.

There was also a growing emphasis on joint working needing to involve significant rationalisation of functions to meet anticipated budget shortfalls.

Challenges/barriers

Even areas with strong joint working arrangements identified it as an area for ongoing development.

The main barriers were perceived to be the differing organisational cultures, accountability, governance and delivery requirements of different organisations. Institutional resistance to sharing resource and risk was also a key factor.

National level silos in central government departments were also seen to be played out locally via different priorities, targets and accountability regimes, often with conflicting targets.

Joint working appeared to be far more complex and challenging in two-tier areas and areas where there is no co-terminosity between local authorities and Primary Care Trusts (PCTs).

Some authorities also suggested that there are stronger bilateral arrangements between health and adult social care than children's services. This was due to differing priorities for children in the area of safeguarding and child protection in children's services.

The nature of what 'commissioning' represents is understood very differently in children's, adults' and health services, and this makes developing joint approaches harder.

Joint appointments need to be done well to avoid the appointee being seen as being from one organisation – there is also a risk that they spend all their time servicing partnership meetings with insufficient time to act strategically.

Support

Interviewees were aware of general, high-level support – for example, conferences, guidance and general research on joint working, and some cited specific support accessed through either the IDeA, their local authority or strategic health authority (SHA) locally.

The greatest demand was for targeted support specific to local circumstances (for example, facilitated workshops, action learning, peer reviews, support tackling difficult issues/barriers, etc). This reflects the fact that there is no one 'standard model' for joint working.

There is interest in best practice and 'what good looks like'. This needs to be done in a way that makes the learning transferable and recognises that each local arrangement is different.

Interviewees were very clear that any support should take into account the wider partnership agenda – not just on the links between health, adults' services and children's services, but on the wider determinants of health and the links with other directorates at the local level.

3.0 Introduction

Shared Intelligence was asked to undertake a scoping exercise to explore the effectiveness of joint working arrangements between directors of public health (DsPH), directors of adults' social services (DsASS) and directors of children's services (DsCS), and examine what further support and development opportunities may be needed to foster good local joint working.

The aims of the project were:

- to find out what appetite there is among DsASS and DsCS in particular for more joining up (with DsPH) at the local level
- to establish what joint working already exists, how well these arrangements are functioning and how effective is the joint working
- to find out what opportunities for joint development are already provided at a local, regional or national level
- to find out what activity / support would be useful to improve / further develop relationships locally.

Methodology

The exercise employed an 'enquiry approach' using a combination of desk research and telephone interviews with pre-selected local authorities to identify what is needed to improve and further joint relationships locally – and how this can be supported.

Fifteen local authority areas were selected by the ADPH, IDeA and Shared Intelligence to reflect a mix of political, geographical, governance and partnership arrangements. A reserve list of authorities was also compiled and, where necessary, DsPH, DsCS and DsASS from this list where asked to participate to ensure an even spread of responses was obtained (see Appendix 1 for a list of all the participating authorities).

In each of the authorities, semi-structured telephone interviews were carried out with the:

- director of public health
- director of adults' social services
- director of children's services.

In conjunction with the IDeA, five authorities were identified for wider stakeholder interviews, which included local authority chief executives, PCT chief executives and lead members for health and social care and children's services to provide a more complete picture of partnership working locally.

In terms of the document review, a short national document review and a local document review were undertaken for each of the authorities interviewed, which captured any work that ADASS, ADCS and ADPH have completed to assess the appetite for and evidence of joint working.

This report

This report presents the findings of the scoping exercise which took place in June 2009.

- section 4 outlines the background and context for joint working between DsPH, DsASS and DsCS
- section 5 outlines the appetite and rationale for joint working
- section 6 outlines the existing arrangements for joint working
- section 7 details key findings on the perceived benefits of joint working
- section 8 explores the main challenges for joint working and joint appointments
- section 9 outlines existing forms of support and ideas for what support would be useful in future.

4.0 Background and context

Joint working arrangements between the DsPH, DsASS and DsCS are built from a wider understanding that partnership working is the best way to ensure that services are cost effective, person centred and needs based. Such arrangements are also important to the 'delivery priorities' identified by local strategic partnerships (LSPs), local area agreements (LAAs) and joint strategic needs assessments (JSNAs). As the Audit Commission recently noted, there is 'nothing new in local agencies working together voluntarily to deal with complex challenges'.

The long-term evaluation of LAAs and LSPs (CLG 2008) found that an important facilitating factor in effective partnership working is the quality of local relationships. This study said that to break down local barriers to joint working, senior partners needed to embed partnership and change silo-based working cultures, champion LSP/LAA priorities and build them into service/corporate plans, and ensure transparency in the deployment of funding.

These findings are relevant to joint working on health as well as wider partnerships as they raise questions about the extent to which structures such as the JSNA or joint appointments have brought DsPH, DsASS and DsCS closer together. The next two sections look at previous factors that have influenced joint working between the DsPH, DsASS and DsCS, and the nationally expressed appetite for joint working.

Good public health is not just the business of the NHS

The factors that have influenced joint working between the DsPH, DsASS and DsCS have been threefold. The first was the push toward 'outcome focused' improvements in public health and children's services which established 'the duty to cooperate' within the 2004 Children Act and *Our Health, Our care, Our Say* (2006). It ensured more visible local leadership on issues regarding health and wellbeing and more appetite for efficient partnership working between PCTs and local authorities through greater use of joint appointments, pooled budgets, children's trusts, LSP health and wellbeing groups, and joint commissioning arrangements.

Another factor has been the establishment of joint appointments between PCTs and local authorities since 2005, through directors of public health or shared chief executives. In 2006, the Association of Directors of Public Health (ADPH) proposed a national framework for jointly appointed DsPH entitled *Public health: Fully engaged*. It was an attempt to gain a shared understanding of the roles and responsibilities of these newly created posts. The document stated that 'there is no one model that can describe the ideal configuration of public health systems' because of the varying governance structures and size of local authorities and PCTs. In essence, solutions, the 'appetite' and capacity for joined-up working for the DPH would be derived locally. The DPH role was therefore conceived as follows:

- As a senior post that should have membership of the PCT and local authority board and have dual accountability. The leadership of chief executives will be needed to consolidate the appointment.
- To work under a Memorandum of Understanding with key policy intentions and mutual commitments in terms of annual objectives and devolved/joint budgets (fair share contributions).
- As having professional independence and an advocate for the population in promoting and protecting health.

- To forge strong working relationships with the cabinet and particularly the lead member for public health.
- To ensure effective delivery of the public health function through an integrated work programme with the DASS and DCS.
- To be accountable for delivery and performance management procedures of the LAA and the then Corporate Performance Assessment and NHS local delivery plans.
- To have access to the administrative and logistical support of the PCT and Local Authority (LA).

The last major factor that has influenced joint working between the DsPH, DsASS and DsCS is the Local Government and Public Involvement in Health Act 2007, which required PCTs and local authorities to produce a JSNA of the health and wellbeing of their local community. The DPH, DASS and DCS were required to work jointly to undertake the assessment to create a shared understanding of the priorities. The guidance also stipulated that 'jointly appointed directors of public health can facilitate the process by working across health and local government. For PCTs, the world-class commissioning assurance model will ensure that PCT Boards take an active interest in JSNA' [1]. DsPH therefore obtained a centrally led remit to establish joint working procedures.

National appetite for joint working

The national appetite for joint working between the DsPH, DsASS and DsCS was difficult to ascertain through national-level literature because of the sparse nature of information about such activity.

Some national-level appetite for joint working among national professional associations can be derived from the 2008 outcome paper from the ADPH, ADCS and ADASS joint conference, entitled *Inequalities and Wellbeing – Working Together.*

It was the first time all three associations had come together at a national event with regard to a cross-cutting issue. Keynote speakers included the presidents of the three associations and representatives from the Department of Health, Children's Schools and Families and Care Services Improvement Partnership. The conference also revealed that the ADPH, ADASS and ADCS felt they were travelling in the 'right direction', but there were a number of issues to address. These are outlined in Box 1.

1 Barton, H., & Grant, M. (2006) A health map for the local human habitat. *Journal of the Royal Society for the Promotion of Health* 126 (6) 252–253.

Box 1: Issues to address for joint working – identified at the ADPH, ADASS and ADCS annual conference 2008

NATIONAL ISSUES	LOCAL ISSUES
• The variable interpretation and implementation of joint appointments. • The debate on whether the DPH role should necessarily remain based within the NHS. • The missing links with local authority economic development functions in relation to health equalities.	• Avoiding unnecessary duplication in recording the individual's story, then safely sharing and using the information so our interventions can make more of a difference. • Keeping wellbeing and wellness at the forefront, and planning services based on prevention and early intervention. • Shifting choice and control from professionals to users/patients. • Transferring activity and finance within care pathways. • Joining two commissioning frameworks. • Achieving user satisfaction and clinical outcomes.

The conference closed by asking how the three associations could continue working together regionally, nationally and locally – showing a commitment to future joined-up initiatives. The IDeA's Healthy Communities Programme also agreed to support wider local authority and PCT joint working through sharing good practice and supporting this scoping exercise.

Bilateral arrangements also exist at national level within the trilateral group. For example, the ADPH and ADCS published a joint publication on the *Principles for Successful Joint Commissioning in Children's Services* (May 2008). It sets out eight agreed principles, which include the need for inter-agency governance arrangements like children's trusts and organisational accountability through joint appointments.

National literature also identified an appetite for joint appointments (at chief officer level and through DsPH) with arrangements for these roles varying across the county. The IDeA further identifies the JSNA as a vehicle for trilateral joint working.

More recently, the IDeA published *Perspectives on Joint Director of Public Health Appointments* (2008). This work aimed to provide an analysis of the joint DPH role from a local authority perspective. The report showed there is some way to go in understanding the impact and effectiveness of joint DsPH as there is a significant 'absence of systematic and independent study of their impact and effectiveness'. The report suggests the following ideas:

- What matters most is how the joint appointment is used and the way the appointee contributes to the development of local policy, priority setting and implementation of the changes needed to improve the health of all citizens, particularly those who are most deprived.
- As local authority structures, cultures and processes differ across the country, no single nationally defined role for a DPH is likely to work in all settings (therefore, six models for the role are proposed in the report).
- The skills and experience of the individual DPH and the operating environment of the council are critical to success. Joint appointments are difficult as PCTs and local authorities are very different organisations. Those who hold these posts need to establish trust to be successful across two organisations.
- The personal skills set that each DPH holds must be matched to the capacity that the local authority has to manage change and deliver real outcomes for citizens.

The contextual appetite for joint working could therefore be considered to be good nationally; there is commitment from the three relevant professional associations and clear steps towards change through joint appointments and the JSNA.

5.0 The rationale for joint working

The interview responses suggest a strong local appetite for joint working between DsPH, DsASS and DsCS. This relationship is very much part of existing partnership working arrangements within local authorities, such as local strategic partnerships, senior management structures and joint appointments with the PCT.

Much of this appetite at local level was demonstrated through joint work on cross-cutting issues within the health agenda. Many local authorities felt that health was 'no longer just an NHS issue' as there was a significant role for DsCS, DsASS and DsPH in public health, particularly in the area of prevention. Interviewees felt that the key to achieving better health outcomes for all was through 'joint work', where there was a combined understanding and sharing of expertise when approaching targets. This approach sees 'health' as a cross-cutting issue, one that is affected by many aspects of the locality.

A number of cross-cutting themes/agendas were identified by respondents as gaining greatest appetite for trilateral and wider partnership work. Nearly all were within health inequalities or public health and were considered to 'be the result of multi-causal issues'. The DCS, DASS and DPH relationship was also seen as being particularly important when tackling high-profile issues, particularly with regards to safeguarding children and adults and emergency planning.

The themes are outlined below:

- **Child and adult obesity:** Maintaining healthy lifestyles by combining community services, child and adult education services, health and regeneration. Many respondents spoke of a family-level approach here.
- **Teenage pregnancy:** Decreasing the rate of pregnancies by working with children and young people services, education, health and social care and primary care. Many PCTs also operated joint commissioning and joint appointments in this theme.
- **Child and adult mental health:** Tackling many aspects of emotional wellbeing – particularly within deprived communities – involving health, employment and skills, education services and social care. Many authorities operate joint commissioning arrangements here.
- **Transitions – child to adult care services:** 'Because a child becomes an adult', the transition from child to adult services was frequently cited as a major reason for bilateral working between DsCS and DsASS.
- **Perinatal and infant mortality:** A priority for a few areas as an issue within certain communities that required a combined primary care (natal care), education, children's services and public health response.
- **Safeguarding children:** Identified as a high national and local priority, joint working was observed between all three directors, and bilaterally between the DCS and DPH. Other partners such as housing, the police and probation services were involved to take a 'family perspective'. The safeguarding of vulnerable adults was also a shared priority.
- **Low life expectancy:** Often said to be connected to high levels of deprivation, and disparity at ward level. A number of authorities were tackling this through joined-up initiatives with housing, community services and economic development teams.
- **Personalisation of care services:** Giving those using care services the ability to choose which ones they use. Some authorities are using or piloting personalised budgets that require joint working between the DCS, DASS and DPH as well as private providers (banks, care providers, etc).
- **Migration:** Supporting new migrants was seen as a priority for local authorities experiencing seasonal migration. 'Joint working between the three directorates and the housing department ensures that essential services are available to newcomers'.

- **Bed blocking:** Reducing the length of non-essential hospital admissions was mentioned by local authorities as a priority for health and social care, and often involved joint work between the DPH and DASS.
- **Learning and physical disabilities:** Cited as an important area for joint work which involves joint commissioning strategies and arrangements for personalised care. Joint working occurs with the three directorates and other partners, such as housing, planning, community services (libraries, leisure facilities) and adult education.
- **Infection control:** Most recently, work to control the spread of swine flu. The DsPH at the time of interview were working very closely with primary health services and local authorities ensure up-to-date information and emergency plans were being developed.
- **Drug and alcohol misuse:** Another area for joint commissioning between the PCT, local authority children and young people services, and drug and alcohol treatment services. Many local authorities also highlighted the importance of including housing, employment, voluntary, police and probation services.
- **Smoking cessation:** A high priority for the health services (DPH) which has support from DASS, community services and sometimes the DCS – usually via the LAA. 'The common theme here is to achieve healthy lifestyles, give support for people who want to quit and promote more physical activity'.

The JSNA was also seen as a key driver of joint working by bringing the DCS, DPH and DASS together to evidence, identify and prioritise major issues within the local population. While interviewees said that the JSNA was often led by the DPH, they also felt it was a document they could 'jointly own' as they soon realised that the 'JSNA was not just about health'. The JSNA process was said to 'get one view of need; we have one set of data which is owned and understood'. Areas which perceived their partnership working to be well established did not see the JSNA as a 'significant driver' for joint working, but as another piece of architecture, 'supportive of the priority-setting process'.

Similarly, many interviewees felt that the LAA was a good method of focusing on specific targets and using the system to performance manage progress. The progress on targets was also thought to be reflective of the success of wider partnership arrangements.

Many local authorities also felt that the joint working had 'moved on' from a focus on trilateral arrangements towards the wider determinants of health – quality of life. This includes employment, education, housing, environment, regeneration, crime and fear of crime, etc. 'We take a whole-community approach – it's not just about the three of us – it is absolutely essential to include the local strategies on housing and work agenda/employment'.

Areas with mature partnership working arrangements identified joint working between directors as an area for ongoing and further development. The appetite for joint work was not seen as a short-lived 'phase'; it had the commitment to continue.

6.0 Existing arrangements for joint working

There are a wide variety of locally derived formal and informal structures that bring together DsCS, DsASS and DsPH. Many of these are locally derived to suit the needs of the locality and existing partnership arrangements.

Formal arrangements between DsPH, DsCS and DsASS

A minority of local authorities had monthly and quarterly tripartite meetings about key health inequality priorities for their area. These were seen as beneficial for providing momentum for a shared priority, and critical in further strengthening the relationships of the three directors.

The majority of areas had joined-up structures within a wider management or partnership forum – for example, all three directors may be members of:

- the senior management team (chief officer groups with PCT and local authority chief executives)
- combined director and chief executive meetings of local authority and PCT
- local strategic partnership and its thematic partnerships which provides access to health and wellbeing partnerships and children's trusts / young people's partnership
- joint strategic commissioning board / management team (on themes such as mental health, learning disabilities or social care).

The most common reason for this by far was that partnership working was more widely embedded within the local authority and the PCT. 'Partnership is the way we work, it is part of our fabric and has been for a number of years, we cannot work any other way now'. Trilateral working was therefore seen as an arrangement that sits within this structure and in no way a separate priority.

A focus on tripartite relationships therefore seemed out of step with wider partnership arrangements in many authorities – in many cases, interviewees told us that the agenda had moved on considerably to looking beyond shared priorities in health, adults' services and children's services, to a wider mainstreaming of health targets and outcomes. It was therefore assumed that the DPH, DASS and DCS would work together. More significant challenges were felt to be about engaging other directorates in the health agenda.

Joint appointments

Almost all the areas contacted had formal DPH joint appointments between the local authority and the PCT. Where there were some exceptions, it was because the DPH was seen to work successfully between the PCT and local authority as part of joint health units or existing partnerships, and they 'did not see the need to formalise the post as 'joint' when the system already worked well'.

Bilateral meetings between DsPH and DsCS and DsASS respectively are more common than trilateral arrangements. This may be because local strategic partnerships tend to separate adults' health and wellbeing from children's partnerships (often reflecting LAA targets and children's trust structures). Another reason is that some areas have combined the DASS and DCS function in one appointment so they do not see themselves as working trilaterally.

Many DsASS and DsCS and wider stakeholders also felt their jointly appointed DPH was a good source of overview within formal structures as the role was vital in working bilaterally with children's and adults' services, often acting as a 'broker' between the local authority and the PCT.

Similarly, DsPH have regular access to elected members through formal structures, i.e. the DPH may meet the lead member on health on a monthly basis through the health and wellbeing partnership. The role of the DPH is therefore close to the cabinet, providing a process for dialogue and shared learning on public health. 'Providing members briefings on public health is a vital and appreciated part of the role of a joint DPH'.

In one area, elected members form an integral part of the governance model for their social-care arrangements by sitting on the board of directors. Three councillors take non-executive responsibilities for culture, leisure and healthier communities, adult social care, social services and regeneration.

Informal arrangements

Informal contact and personal attitudes were seen as being as important as formal structures. For example, some local authorities have co-located adults' social care staff alongside PCT and children's services staff to fully integrate public health services. Co-location is often bilateral, being used to support closer working at a physical level between two directorates, encouraging day-to-day interactions and the sharing of IT systems and staff. The informal networking at formal meetings was also seen as a good source of decision making on specific health priorities.

7.0 Benefits of joint working

Interviewees highlighted a number of significant benefits to joint working, stating that they often outweighed the challenges. Similar benefits were cited whether they were in the context of trilateral working or wider partnership working in the locality. Examples are outlined below.

- **Better public health / health outcomes:** All areas interviewed believed that with a combined approach, significant improvements to health outcomes can be achieved. Public health was a policy area where there was a need for a whole-systems approach: 'One that could see an individual as part of the family, community and service user'. A particular emphasis was put on the need to reduce health inequalities among certain populations by increasing the provision of preventative health.
- **Better quality of life for the population:** A number of areas also pointed out that from a long-term point of view, the aim of joint working is to improve the quality of life, not just health outcomes. This means 'a shared understanding that quality of services, amenities, housing and environment need to improve in order to build healthy people'.
- **More effective prioritisation:** 'When joint working arrangements are made, they allow for more effective priorities to develop'. The JSNA is a tool that many interviewees felt to be a positive process of building a picture of need in which the DCS, DPH and DASS functions could jointly identify and plan for.
- **Increased ability to influence:** As a trio, many directors felt that they could increase their ability to influence senior decision makers at chief officer meetings and partnership boards. DsPH emphasised the importance of having access to senior management meetings as 'they open doors within the local authority that would previously have been shut to the health service'. It was felt to be a significant shift in culture.
- **Effective communication:** The joint working arrangements of directors was said to improve communications between their directorates both horizontally and vertically. 'The fact that we work together has led to economies of scale, sharing communications teams and an increase in dialogue'.
- **Reduced bureaucracy:** Effective joint working around shared priorities was seen to reduce bureaucratic processes by streamlining them towards outcomes rather than process issues. 'A greater focus on the results'.
- **Improved efficiency by sharing resources (staff and budgets):** Value for money was cited by nearly all interviewees. Improved efficiency and cost savings are a priority for PCTs and local authorities alike. 'It is the logical way forward, and those who have taken it know they would never go back'.
- **Less confusion (single accountability) for service users:** A number of interviewees commented on the way services should 'work seamlessly for their users'. One of the key benefits of joint work will be to provide less confusion for the user when they need to access services. 'The responsibility for public health falls on all the directorates if we work together and there is scope to provide a universal service'.
- **Less duplication through joint planning:** Following on from the point above, a seamless service also allows for less duplication, which is particularly true of social care, primary care and children's services. This duplication was felt to be 'confusing for the user, unappreciative of actual need and inefficient'.
- **Development of new skills sets through shared learning:** Many interviewees spoke of the individual benefits of joint working. A process of 'learning new skills and seeing health from another perspective'. Many of the elected members commented on their increased understanding of public health. DsPH, DsCS and DsASS felt that the interaction led to 'long-lasting changes to perspective' when planning and commissioning services.

- **Innovative / creative / holistic approaches to the provision and commissioning of services:** Joint work was also said to drive innovative practice, plans and ideas. 'By meeting together on one issue, voices from all parts of the local community can be heard; the VCS offer innovative suggestions as well as the DCS or DASS having more understanding of issues on the ground'.
- **Shared accountability and integration:** Those areas which felt they already operated effective joint working arrangements said that in practice, the benefits far outweigh the challenges. 'Integration of the DPH, DCS and DASS is the first step in wider moves to integrate more fully'. This suggests that integration is considered to be a benefit that should filter through wider partnership working.

Interviewees once again emphasised how they understood joint working in a wider partnership context (whole senior management team(s) and/or local strategic partnership), as this was where both the real organisational and delivery benefits were derived and a focus on wider health and wellbeing outcomes achieved. Many referred to the need to 'achieve better health outcomes for all', 'improve quality of life' or 'a reduction in health inequalities' as their primary aim, because it could bring partners and directors from all departments together. There was a common understanding that trilaterally or bilaterally, organisations 'had to' work together on health issues from a 'whole-community perspective' to achieve their aims.

There is also a growing emphasis on the way joint working could involve the significant rationalisation of functions to meet anticipated budget shortfalls. It was clear that joint aims lead to joint priorities and delivery mechanisms – interviewees felt this was the 'only way to create efficiencies and adjust to the current economic climate'. Many local authorities spoke of moves towards wider joint commissioning strategies and teams to embed joint working practice in front line services. Others went further to identify the merging of functions, sharing of back office support and reshaping of workforce skills to support new integrated delivery models.

At an individual level, DsPH commented on how their joint appointments made them feel like a part of the 'local authority machinery', a 'trusted advisor and broker between the PCT and local authority'. Many DsPH also re-emphasised their enthusiasm for working with elected members and felt it was beneficial to democratically legitimise the public health agenda.

8.0 Challenges and barriers

Joint working

The most frequently cited barriers to closer joint working were perceived to be the different accountability, governance and delivery requirements of a PCT and local authority. Many interviewees pointed to 'the challenges of working between two different institutional cultures', raising particular concern about knowledge gaps in understanding 'how each other' worked. Some interviewees felt that there was a much stronger understanding of the strategic approach to joint working and integration, but far less about practice and the skills and knowledge needed to deliver integrated front line services.

The difference in governance arrangements between a PCT and a local authority has implications for joint working. PCTs are accountable to their strategic health authority and DH, which take a strategic perspective on health issues and delivery. When joint DsPH come into post, they 'soon realise the importance and impact of democratic accountability – decisions can take longer and are made for localised reasons'. Having said this, DsASS and DsCS found PCT structures frustrating because of the 'dominance of centralised policy making in health'. Some authorities also thought that the health service was going through a wider cultural shift by moving towards preventative health, and it may take time to adjust.

Collaboration also seems very challenging when institutional structures have separate terminology and operating systems. A few jointly appointed interviewees highlighted that the PCT and local authority have difficulties sharing public health data, IT systems and maintaining communication lines. For example, it was not unusual for a joint appointee to have two different email addresses or different terms and conditions of employment.

An example of where particular operational confusion can occur is in differing understandings of the budgetary cycle. Local authority departments often work to the completion of year-end budgets, but when joint DsPH come into role, they are experienced in making health service budgetary efficiencies (where money not used in the current financial year is carried over). The implications of such confusion can lead to unused resources and joint arrangements failing to deliver.

Institutional resistance to sharing resources and risks, and differences in organisational cultures are also key challenges. 'It is hard to get people around the table to think beyond health and social care and commit to actions that take a whole-community perspective'. This also depends on where the resource is located – for example, a DPH based in the PCT with a team behind them will have more influence in the organisation than in the local authority, where they cannot always offer the resources that other directors can.

A lack of sufficient joining up between departments at the national level was also cited as challenging. This was often felt to 'play out' locally via different priorities, targets and accountability regimes, as well as conflicting targets. Local authorities are committed to national indicators that work on a locality basis, while PCTs commit to targets that are more process driven, i.e. waiting times / GP referral times. These performance measures as a whole were not felt to 'marry up, with the latter having little relevance to public health outcomes'. In addition, some interviewees felt that the Comprehensive Area Assessment (CAA) and World Class Commissioning (WCC) were competing priorities locally. PCTs were clear about SHA and DH expectations, that their focus should be on WCC, whereas local authorities were focused on the CAA. The difficulty is how to resolve these competing demands at the local level.

Some interviewees felt that 'ambiguity was nothing to be scared of, but rather a sign of a mature partnership'. 'It is important to understand that not everything in joint working arrangements will match up – this is a good thing as long as the outcomes are the same and you can work with it'.

Joint working is far more complex and challenging in two-tier areas and areas where there is no co-terminosity between local authorities and PCTs. Joint working by the DsPH, DsCS and DsASS is complicated when the local authority has unaligned boundaries. For example, one two-tier area can have the following make up: 12 district LSPs, 2 unitary authorities, 5 PCTs and 5 DsPH (one of which is jointly appointed). In this situation, areas reported difficulties getting PCTs on board and providing capacity for the joint DPH to engage with all these structures and partnership arrangements.

Some local authorities also suggested that there are smoother bilateral arrangements between health and adults' social care than children's services. A few DsASS saw children's services as a 'difficult beast, hard to engage on public health as a priority because of the over-dominance of the safeguarding and child protection agenda'. Bilateral working between the DPH and DCS/DASS was cited more often than the DCS and DASS, although a few local authorities had combined these roles into one post to ensure the two were integrated.

Another reason could be that what 'commissioning' represents is understood very differently in children's, adults' and health services, and this makes developing joint approaches harder. 'The split within PCTs between the commissioning and provider role has led to some polarisation of the organisation'. PCTs are seen by interviewees as more strategically focused than the local authority, which focuses on detailed delivery. The pace of change within the health service is fast and joint working arrangements are not always able to address this.

Joint appointments

Joint appointments need to be well structured to avoid appointees being seen as being from one organisation. Their capacity to work across organisations was highlighted as a concern. A significant proportion of DsPH reported they spend all their time servicing partnership meetings and have insufficient time to act strategically.

Reflections on the joint roles were generally positive; the only barriers were that DsPH needed more training in local authority operational systems and more appointments from a non-primary care background. This was because DsPH were considered to be more likely to take a primary care perspective on key public health issues rather than thinking more widely for the locality (worklessness, quality of life, etc).

A further reflection on the role of the DPH was its ability to be seen as 'independent' and to use this to challenge local authority and PCT colleagues. A few DsPH spoke of how they attended meetings and could see both sides of the coin during funding allocations. DsPH are 'very careful to be impartial when major funding decisions are made'.

In more established partnerships, joint appointments were seen as so successful that there are plans to implement them at second-tier management level or operational level, i.e. employing a public health officer in children's services. Other areas had a 'wait and see' approach about their joint appointments as they have only recently come into post.

9.0 Areas of support

Existing support

Directors were aware of national high-level support available to them for developing joint working arrangements. These included:

- guidance from the IDeA, Audit Commission, ADPH, ADCS, ADASS, the Department for Children, Schools and Families (DCSF), the Department of Health (DH), Communities and Local Government (CLG), etc. – for example, interviewees cited support available for doing JSNAs through written guidance and events
- general research from the above organisations
- national conferences provided by the above organisations and other providers
- support from their Regional Improvement and Efficiency Partnership (REIP)
- Department of Health national support teams
- 2008 joint conference of associations.

Many interviewees also cited that 'if we need support, we often source it ourselves', and have used local or regional development resources from the IDeA, leadership support within the local authority, regional health networks and professional development through the SHA.

Examples of local training and development included facilitated support through the LSP and/or regional chief executives group; some internal leadership development activities; sessions led by PCT; and 'joint innovation days', bringing together staff across service areas. There was also one example of an existing learning set of PCTs in one sub-region, and health inequalities assessments were sited as useful by a number of interviewees.

However, in spite of this, most interviewees were not able to give very many examples of support they had accessed or particularly valued. People who had accessed existing support also said that while some of the support was fairly useful and worked reasonably well, they recognised that it was a bit 'patchy'.

For example, interviewees highlighted some regional support that was available mainly from SHAs (or, in one case, from a public health observatory). Interviewees said that while the SHA is good at health-led initiatives, it is not always so good at making the links to local authorities. One interviewee said that 'joint work with PCTs is not really understood by the SHA – they do not understand the wider pressures of the local authority remit'.

Ideas for future support

From the study, it was clear that there was an appetite for support of joint working, but that this was primarily in the context of wider partnership working rather than a narrower focus on the relationship between DsPH, DsASS and DsCS.

Most interviewees indicated that there were ongoing development needs with partnership working, and that there was a need for appropriate support and that it would fill a gap. There was a small number of interviewees who were clear that any support would and could be sourced by them, and if anything, there was a need to 'streamline' the support offered nationally.

In terms of the type of support, nearly all interviewees who identified a need for support wanted it to be targeted and local. It should be specific to local circumstances to allow for the fact that there is no standard model for joint working between the DPH, DCS and DASS. Particular requests were made for facilitated workshops and interactive formats such as action learning, which would provide support to tackle sticking points such as:

- challenging agendas, such as teenage pregnancy rates, infant mortality and elderly care
- joint commissioning (including in the context of 'Total Place' pilots)
- governance of joint working arrangements
- funding, pooled budgets – understanding the different health and local authority regimes
- workforce reform

- joint performance management frameworks
- health inequalities
- knowledge management and data sharing
- greater clarity of the DPH role – 'some technical and legal support for DsPH on their roles would be useful at a local level'.

Elected member support should also not be forgotten – some directors and a small number of members echoed officers in identifying difficulties in knowing 'what works'.

The important thing to note was that interviewees emphasised that local support would be particularly useful for specific issues, with one interviewee saying 'keep it local to keep it relevant to need', whereas regional support would be valuable where there are common interests for similar areas (as opposed to national support, which is in danger of becoming too large and general).

Due to the localised nature of health inequalities and public health issues, support may be best targeted at developing the 'skills' in DsPH, DsCS and DsASS to recognise and develop effective joint working. Areas are also interested in accessing tools that can help them to address the difficulties of joint working and so 'identify for ourselves what is needed and what works well'. In particular, the skills sets needed in middle management were raised as well as the need to support organisations to develop the skills needed to work in an integrated way. One interviewee summed this up as 'there is a lot of evidence of what works at a strategic level, but drilling down below is harder'.

There was particular interest in where joint working has translated into real outcomes on the ground – rather than simply good structures, as one interviewee explained: 'it's the how to implement, rather than building relationships'.

Action learning sets and targeted workshops designed around particular issues were often cited as an especially useful format. Interviewees said that they would need to be tangible and interactive, and expert speakers, project-based learning and discussion groups would help to tackle real issues. Peer reviews were also viewed favourably, particularly if they could be linked to the LAA and CAA, but shouldn't be delivered in a way that feels like another inspection.

There was also interest in secondments, mentoring, the brokering of peer support and support for stronger networks that cut across traditional DPH, DCS and DASS groupings.

There was a lot of interest in understanding best practice or 'what good looks like', and in understanding the structures that existed in more established partnerships and how to engage partners wider than the DPH, DCS and DASS – 'some issues are common – if there are people who have got through it, it would be useful to know how'. This support needs to be delivered in a way that makes the learning transferable and recognises that each local arrangement is different.

This is echoed by areas widely considered to be 'best practice', suggesting they are stretched by the number of requests to present their 'model' at conferences and seminars. Similarly, directors said that they have limited capacity to attend national events, which provide little or no focused learning. To develop wider local assistance, there could be more effort made to look at the factors that assist and the factors that challenge effective joint work from these examples. It was suggested that online resources and templates could provide support for this.

One way forward may be to further develop the applicability of the model below (see Table 1), which has been adapted to the findings outlined above. It identifies the helps and hindrances of joint working, acknowledging the relationship between the three directors as a wider constituent of partnership arrangements.

Table 1: Joint working: helps and hindrances

HELPS	HINDRANCES
• Good relationships between DsPH, DsASS and DsCS. • Good relationships between chief executives, members and PCT board members. • Leadership, shared appetite for change at senior level and 'championing' of partnership working within organisations. • Robust culture of partnership working across the piece. • Established partnership structures – with focus on joint outcomes. • Single joint strategy in place, supported by robust JSNA. • Early wins from partnership and ability to demonstrate benefits. • Political stability – elected member engagement. • Seizing opportunities to strengthen or develop the partnership relationships. • Financial drivers (and belief that pressures are best addressed jointly). • Co-terminosity of organisational boundaries of the PCT and local authority.	• History – for example, over-budget claw backs or past partnership failures. • Conflicting targets and performance management regimes (local and national). • Challenge of making joint accountability work and aligning governance. • Different financial and planning cycles and systems (local and national). • Myths and unexplored perceptions of partnership working and organisational change. • The number of bureaucratic hoops – pooled budgets, TUPE, etc. • Different workforce terms and conditions and impact on redeployment flexibility. • Uncertainty about future direction (national and local policy priorities not aligning and impacting locally). • The combination of clinicians, managers and politicians and 'hybrid' forums. • Lack of capacity within joint appointments – servicing two organisations.

Finally, interviewees said that any local assistance should always take into account the wider partnership agenda – not just on the links between health, adults' services and children's services, but on the wider determinants of health and the links with other directorates at the local level.

In terms of the practical delivery of support, some expressed views that more support delivered jointly by the three representative Associations would work well, since they are well-regarded and trusted organisations. Where mentioned, IDeA support was also regarded positively.

The main message is that any support given needs to really add value and support the delivery of tangible outcomes. One interviewee summed this up as the '…need to think about VFM – if my DPH, DASS and DCS are away on the same day, it needs to be good'.

Other practical issues include:

- a preference for local and regional events (both in terms of focus and keeping travel time down)
- the need for long lead-in times and notice of events
- using video and telephone conferencing to get around the issue of travelling taking more time than face-to-face contact.

10 Conclusions

Overall, the exercise has found that there is a significant appetite for joint working between DsPH, DsASS and DsCS, and a clear understanding of its benefits. Although challenges remain, it would appear that joint working across these roles is becoming embedded in day-to-day practices, and is being seen as an essential way of working, driven forward by the joint appointments and new practices such as the JSNA.

Indeed, many of the interviewees almost took it for granted that DsPH, DsASS and DsCS would be working together on shared priorities, and found it easy to list key agendas that particularly benefited from joint working. There were clear structures to support this, including both formal and informal structures and arrangements, although these vary considerably from area to area.

As such, there was a general feeling that the agenda has moved on now to a wider focus on health inequalities and their wider determinants, particularly among DsPH. Interviewees said that having established joint working on health, adults' services and children's services at the local level, the challenge now was to engage other directors in tackling health inequalities. They noted that more joint working could be done on the links between health and housing, crime, skills and employment, and education. There was clearly an appetite for more joint working beyond the DPH, DASS and DCS.

It was also clear from the interviews that joint working is working better in some areas than others, and that there are still significant challenges to joint working, including the challenge of working across two different organisations; conflicting priorities and targets enforced at a national level; working within two-tier structures and areas where there is no co-terminosity between local authorities and PCTs; and the different nature of commissioning in different service areas.

Appendix 1: List of Interviewees

Area	Role
• Birmingham City	1. Director of Public Heath 2. Strategic Director of Children, Young People and Families 3. Director for Adults and Communities
• Bournemouth	4. Executive Director of Adult and Community Services
• Essex County*	5. Cabinet Member for Adults, Health and Community Wellbeing 6. Director of Public Health 7. Chief Executive, Essex County Council 8. Executive Director for Schools, Children and Families 9. Director for Commissioning 10. Lead Member for Children's Services
• Herefordshire	11. Director of Integrated Commissioning (holding DASS function) 12. Director of Children's Services 13. Director of Public Health
• Kent County	14. Managing Director, Adults' Social Services 15. Director of Children's Services 16. Director of Public Heath
• Kirklees	17. Director of Public Heath 18. Director of Adult and Community Services 19. Director of Children's Services

Area	Role
• Knowsley*	20. Director of Public Heath 21. Chief Executive 22. Executive Director of Wellbeing Services and Chief Executive of Knowsley PCT 23. Knowsley Lead Cabinet Member, Children's Services
• Lancashire	24. Executive Director for Children and Young People 25. Strategic Director for Adults' and Community Services 26. Director of Public Health for North Lancashire
• Liverpool	27. Director of Public Health 28. Executive Director, Children, Families and Adults
• Manchester City	29. Interim Director of Adult Social Care
• Milton Keynes	30. Director of Adult Social Services 31. Director of Public Health and Chief Executive of the PCT 32. Director of Children's Services
• North East Lincolnshire*	33. Lead Member for Children's Services 34. Lead Member for Health 35. Director of Public Health 36. Chief Executive, NE Lincolnshire Care Trust Plus 37. Chief Executive of NE Lincolnshire 38. Director of Care (and Senior Social Care Advisor to Board) Care Trust Plus 39. Assistant Director for Public Engagement

Area	Role
• Norfolk County	40. Director of Children's Services 41. Director of Adults' Social Services 42. Director of Public Health
• South Tyneside*	43. Executive Director of Children and Young People 44. Director of Public Health 45. Executive Director of Neighbourhood Services 46. Chief Executive of South Tyneside
• Southampton	47. Executive Director, Communities, Health and Care 48. Director of Public Health
• London Borough of Southwark *	49. Chief Executive, Southwark 50. Director of Children's Services 51. Lead Member for Children's Services
• Stockton	52. Corporate Director of Children, Education and Social Care 53. Director of Public health

The areas marked with an asterisk (*) were ones selected for wider stakeholder interviews.

Note: A total of 53 interviews were conducted, 7 less than the anticipated 60, which was due to the following reasons:

- some last-minute cancellations of appointments in the last week of interviewing
- difficulty establishing a time for interview to fit DsCS and DsASS and elected member diaries
- some authorities have combined appointments, i.e. children's and adults' services, PCT and local authority chief executives. This reduces the number of stakeholder and director interviews.

Appendix 2: Interview schedule for DSPH, DSCS and DSASS

Introduction

- explain purpose of research – to explore joint working arrangements between DsPH, DsCS and DsASS
- we are particularly interested in the relationship between all three of these roles – trilateral working
- interview should take about 30-45 minutes and will be confidential – we won't be using any names in the final report and will make sure that any quotes or examples used cannot be attributed to particular individuals.

Background

1. Before we start, could you give me a bit of background information in terms of how long you have been in post and how long you have been working at the council?
2. Is your DPH a joint appointment?

Rationale for joint working

3. What benefits do you see in joint working between adults' social services, children's services and health at the local level?
4. Which aspects of your agenda/outcomes/targets would most benefit from joint working? (For example, understanding of local need – JSNA, etc.; new policies – personalisation; cross-cutting issues – obesity.)
5. What level of priority do you attach to developing arrangements for joint working compared to other organisational and service changes? How big an issue is this for you?

Current arrangements

6. What joint working arrangements currently exist? (Probe – formal and informal, structures and processes.)
7. Do you share what you are each doing with each other in some way? (Again, probe how this happens, how regularly, what structures are in place to support this.)
8. What do you want your joint working arrangements to achieve?
9. How well are these arrangements working in practice? (Probe for reasons behind response – why? What challenges/barriers have there been to joint working? For example, demarcation of roles, political balance, organisational boundaries, targets, budgets, performance management, staff skills and practices.)
10. For those with joint appointments (if not already covered above), how well do you think this arrangement is working in practice? Is it helping or hindering joint working? What difference would you say it has made?
11. Do the three of you work together to decide on key priorities for the local area and who will lead on them? (Probe into JSNA as an example of this – how it was developed, how they found the process and how it could have been improved. Was it a new way of working?)
12. Please give an example of when joint working has enabled something to happen that would otherwise have been unlikely to happen.
13. Taking this example, what were the important things about the joint working that 'made a difference'?

Existing opportunities for joint development

14. Are you aware of opportunities for support in developing joint working? (Probe – joint conferences, policy seminars, leadership development, JIP, etc.)
15. Are these local, regional and/or national?
16. Have you taken advantage of any of these opportunities? Which ones?
17. How useful did you find them? Why? (Probe – which opportunities/ support, what aspects were most useful.)
18. Have you been able to use these opportunities to develop joint working locally? Please give an example.

Ideas for future support

19. What support would you find useful to improve and/ or further develop joint working at the local level?
20. How would this help?
21. Would it be building on something that already exists or filling a gap?
22. What would be the main things that would motivate you to participate?
23. What format would you find most useful? (For example, conference, action learning set, peer review, e-network, etc.)
24. Do you think it would be useful to have DsPH, DsASS and DsCS together in one event?
25. What kind of time would you be able to commit? (I.e. would a one-off session be best or a series of events spread over a year or so?)
26. Where would be the best location for you (local/regional)?

improvement and development agency

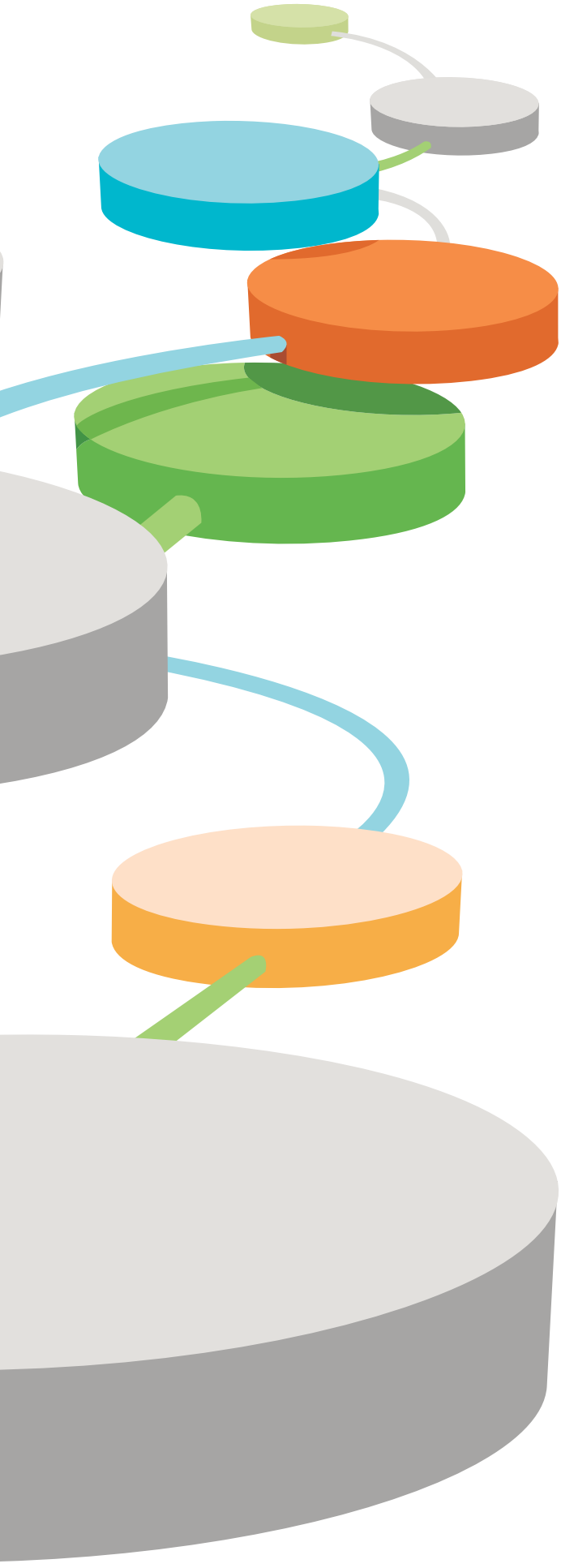
what is the healthy communities **community of practice?**

A community of practice is a network of individuals with common challenges or interests. They are a powerful way for local authorities and their partners to share good practice, disseminate information and aid improvement across the public sector.

The Healthy Communities CoP has been set up to provide a forum for all who are committed to promoting good health in its widest context and reducing inequalities. It enables members to collaborate together to share ideas, good practice, information and knowledge, in order to seek help and solutions, and broaden knowledge to enable the creation of healthy communities for all.

www.idea.gov.uk/health

part of the **LGA group**



The community offers an on and off line forum for individuals involved with improving the health of communities and reducing inequalities to share information with peers across geographical and sectoral boundaries.

what's in it for you?

The Healthy Communities CoP offers individuals:

- an easy to use online platform
- discussion forums addressing a diverse range of health improvement topics
- events including themed workshops, seminars with guest speakers and face-to-face networking
- a searchable document library including case studies, toolkits and research reports
- blogs (online diaries) from a variety of people with their views on current health improvement issues
- wikis (document sharing) enabling the community to shape and develop its own documents, policies and views on health improvement issues
- latest news stories from a range of Government and professional sources
- personal messaging direct to other members of the community.

These benefits enable public sector employees to share knowledge and good practice with a wide range of peers, and to keep up to date with the latest developments, helping them improve their own performance and the service they provide.

how can I get involved?

If you would like to join the Healthy Communities CoP:

1. go to http://www.communities.idea.gov.uk and under 'Register and become a member today' select 'Register'
2. enter your details as requested and select 'confirm and complete'
3. you will receive a confirmation email. Click the link to activate your account and search for 'healthy communities' to locate the CoP.

to find out more about the Healthy Communities CoP contact:

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Local Government Association

The Local Government Association is the national voice for more than 400 local authorities in England and Wales. The LGA group comprises the LGA and five partner organisations which work together to support, promote and improve local government.