Summary of table discussions - ADPH conference 29th November 2007

Summary notes were collected and collated from the 8 tables at the conference – representing the views of around 60 delegates. Clear issues emerged in answer to each question and it is apparent that the delegates were strongly engaged in the exercise. There is a lot that can be taken forward by individual DsPH and the ADPH.

What areas of practice could be successfully transferred to other countries?

Strong leadership

- Commitment to PH at a national level - stability of structures
- Confidence in PH and clarity in our role
- Believable and credible leadership – vision of priorities; clear messages; specific on delivery

Working with Primary Care

- Build on Scottish model of anticipatory healthcare evidence – but limited application of Julian Tudor-Hart model to highly mobile populations
- Use of GMS / primary care to reduce HI
- Adopt Scottish model for addressing health inequalities
- Do not micromanage primary care – but does need money
- Stop QOF exclusions to improve info and analysis

Using clinical model for PH

- Clarifying and developing action linked to healthcare contribution to improving health
- Use of epidemiology / clinical effectiveness / medical model for more immediate NHS perceived gains
- Remember medical interventions to improve PH

Intelligence and capacity

- Intelligence function / role of observatories
- Build on Welsh model – links between PHO / Institute / PH resource
- Potential extrapolation of Welsh model to regions in England – but would require vision and active engagement from RDPH and PH observatory to strengthen PH profile and increase PH information capacity
- Recognition of different levels of PH input (individual / communities / populations) & acknowledgement of added value of DsPH from variety of professional backgrounds
- Build on Welsh model of emphasis on training and capacity planning

Other issues

- Build on (E, W, NI) approach to determinants and develop evidence on timescales and include social justice (Scotland)
- English LAAs promote partnership working
- PH networking
- More resources

How can DsPH & ADPH support the implementation of this?

ADPH support for networking

- Opportunity to share what others are doing
- Share good practice – spearheads that work etc – key success factors
- Network to improve evidence of effectiveness
- Help each other – stable parts to help unstable; support to CMOs from the front-line

ADPH national lobbying

- Help DsPH in PR work by linking to partner organisations (ADSS etc)
- Help to generate emotional support for PH (like environment) - public and media
- Apply pressure to ensure support for existing single-handed DsPH
- ADPH could facilitate discussions on: GPs with specialist interest in PH; sub-specialisms in PH; PH networks; leadership in new world

Focus agenda

- Focus on clear agenda – help DsPH when they get distracted back at the ranch
- 10 High Impact Changes for PH
- Get behind alcohol issue
- Need for good economic modelling between PH programmes and outcomes with potential savings over time

Support for building capacity and capability

- Build capacity – arguments to promote commitment to PH at all levels
- Mismatch between expectation of DsPH / PH teams and capacity for PH delivery
- Transparent model for succession planning & development of specialist and practitioner level as well as DPH and Consultant
- Develop specifications for commissioners to develop PH in the delivery of Children's and Adult services

Local and regional action

- Greater emphasis on longer-term PH issues
- Get agreed regional priorities (LAA linked)
- Locally meet most important people for influencing
- Role of local leadership to support transfer of learning / experience to avoid duplication of effort (essential function of RDPH) – recognising potential conflict in performance management role

What are the three biggest opportunities provided by working with LAs?

Leadership role in LA

- LA platform to be part of civic leadership, contributing to strategic planning from the outset
- On-site for key relationships eg with CEO; triumvirate (DPH, DSS, DCS); exec position
- Joint accountabilities and objectives – facilitate and legitimise dialogue and role
- Influencing overview and scrutiny

Taking forward health improvement & wider determinants agenda

- LAA provides opportunities for resource and shaping existing resources to deliver services (4)
- Forum for sharing, driving and linking to wider determinants of health (2)
- Health and well-being partnership duties to underpin LSPs
- Can link sustainability and regeneration agenda with PH
- Harnessing all health improvement resources - shared priorities eg alcohol; smoke-free

Other joint working

- Being bridge between LA and PCT and using that link to develop PH
- Joint intelligence eg healthcare for older people
- Flu planning etc – real partnership issues

Contributing Public Health perspective

- Develop role of advocacy and understanding of PH perspective - explain health agenda
- Contributing PH perspective to LA led bids and programmes

How can DsPH (and ADPH) exploit these to the full?

Structure

- LAs share costs equally – DPH integral part of both CC and PCT teams – if not it is an issue

Using position

- Being more strategic so can influence eg be integral to planning; lead to co-ordinate action
- Link expectations of LA as part of overall approach to improve health
- Ensure PCT planning reflects requirements of community planning

Ways of working

- Be useful and responsive
- Matrix working
- Delegation

ADPH

- ADPH to work with LGA – behind scenes and publicly
- ADPH to develop tools / frameworks for joint needs assessment

What are the three major challenges?

Status and governance

- Getting LA CEO and Council to recognise status of DPH
- Differential models, reporting chains, accountabilities geographically (2)
- Not to let structure get in the way
- Two tier authorities
- Statutory functions seem to come in at county level – not necessarily reflecting division of responsibilities between councils or areas of influence / interest to public health
- Lack of local control and room for manoeuvre

Resources and skills

- Resources
- Having staff who can do work and able to matrix work
- Skills base
- Personal time management / meeting issues
- Capacity – if you don't have a strong team it is a problem
- Offices in 2 places

Different cultures

- Joint funding
- Joint performance management / indicators
- Inconsistent guidance / legislation about priorities
- Conflicting agendas and priorities
- Maturity of working relationship

Political issues

- Political hue and neutrality
- Members – can be helpful in achieving outcomes but can also be negative (eg against local tobacco control policy)

NHS pressures

- Organisational changes which reduce local community decision making or separate primary care from community
- Expectations of achievement enormous

How can DsPH (and ADPH) successfully manage these?

Structure

- Get LAs engaged in developing joint appointments
- Negotiate with LA to give clarity of tasks
- Break into established management structure

Ways of working

- Clarity of purpose and honesty
- Working relationship with key directors
- Mechanism for joint working without going to all meetings
- DsPH routinely request Terms of Reference for all committees attended
- Remember 'health' may not be high on agenda – try 'well-being'

ADPH

- ADPH work jointly with LGA to develop high level set of joint performance indicators at national level (2)
- ADPH to provide steer on expectations of roles and demonstrate how to get successful relationship management
- Clarify what a good joint appointment looks like – especially what the contribution to PH from LA should be (eg management hierarchy)
- ADPH to give clear statements that add value and translate national statements

What two areas should ADPH consider a priority for lobbying in 2007-8?

- Any new areas at an early stage – make our jobs easier
- Alcohol – wider than just binge drinking debate (4)
- Sexual health
- Health inequalities
- Child health – vulnerable groups eg asylum seekers; unaccompanied minors
- Sustainable development (Impact Assessments)
- Resources / lack of / Choosing Health money (2)
- Fighting pull of the money into acute sector & lobbying by pharmaceutical sector eg Herceptin
- Hospital closure – strategic planning
- Training – especially in softer skills; political skills; influencing etc

How can this advocacy be joined up at national, regional and local levels to provide a stronger voice?

- Direct link with ADPH and CMOs – need to use it more (2)
- Maintain ADPH as network – and multi-disciplinary nature of PH
- Bring together PH voices to give ONE voice - develop multi-agency lobbying for PH – common messages different perspectives
- Clarify distinction between voices – what is unique ref ADPH as opposed to eg FPH. Advocacy should be from ADPH perspective rather than FPH
- ADPH seen to be very good at reacting to issues but needs to be more proactive in horizon scanning and demonstrating leadership
- Link to radical thinkers – radical PH groups and other academic radical groups