

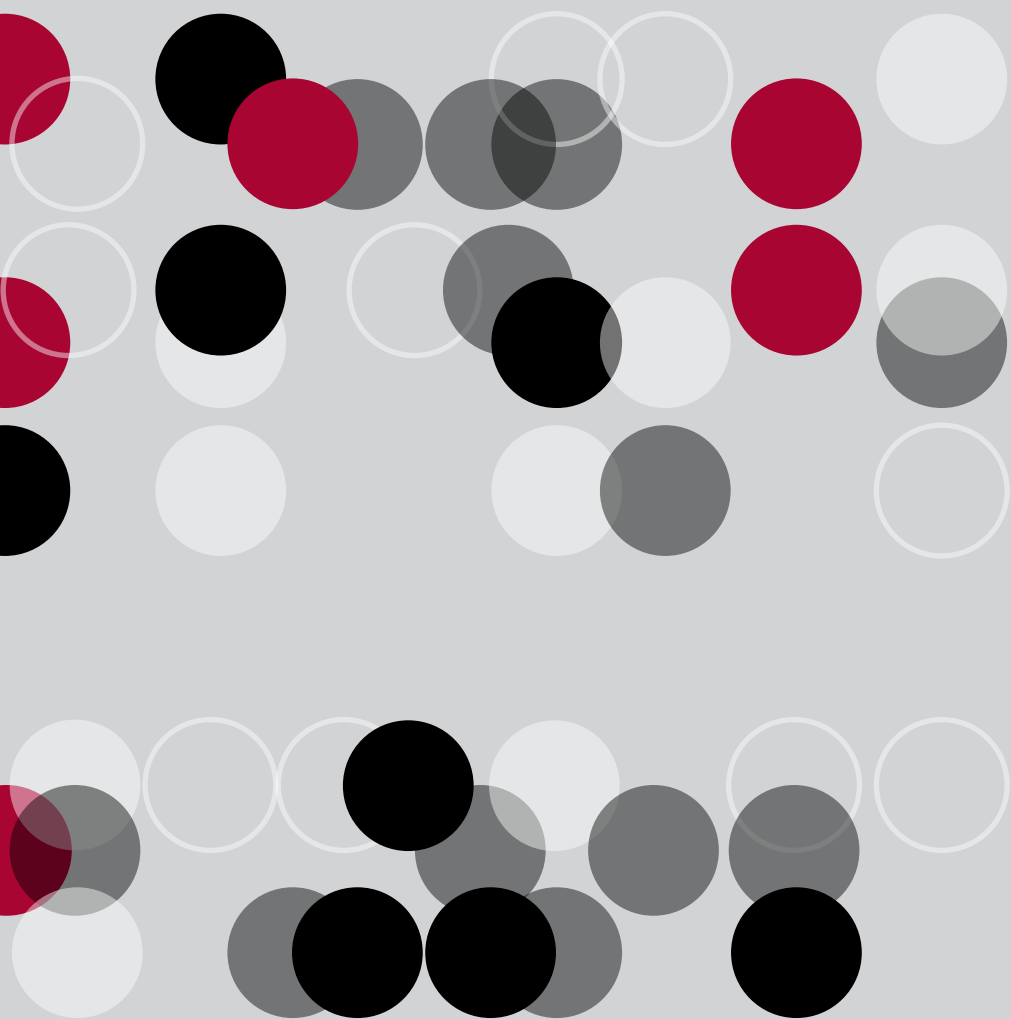


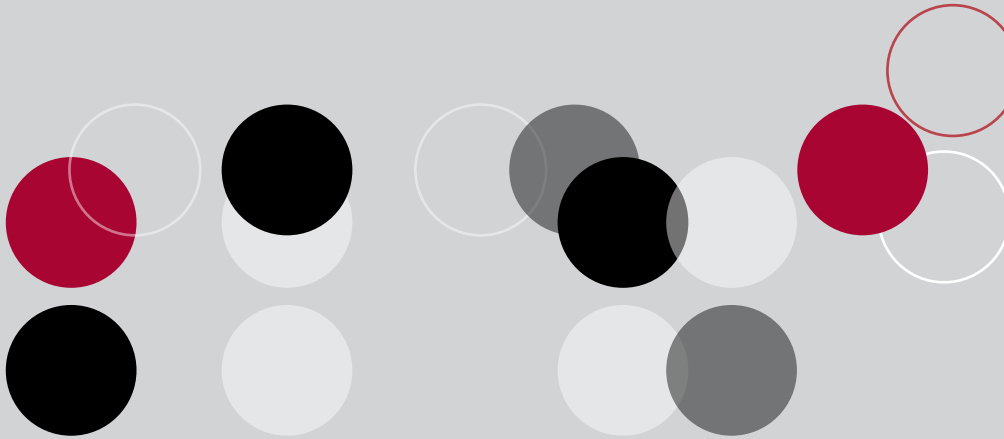
Durham
University

PERSPECTIVES
ON JOINT DIRECTOR
OF PUBLIC HEALTH
APPOINTMENTS

EDITED BY DAVID J HUNTER

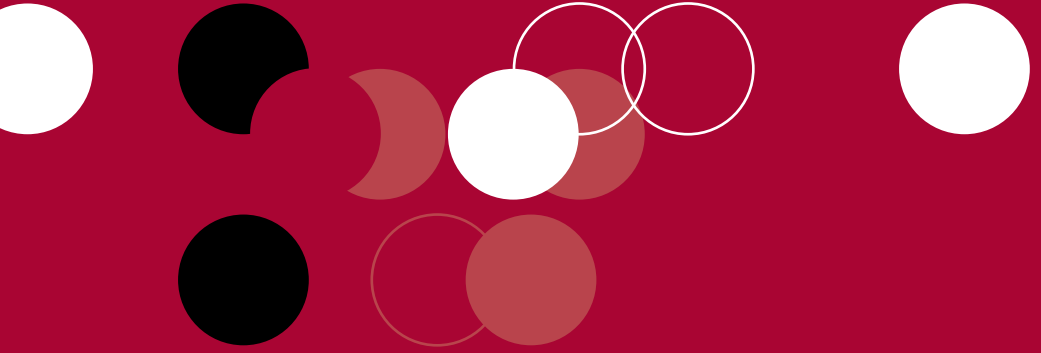






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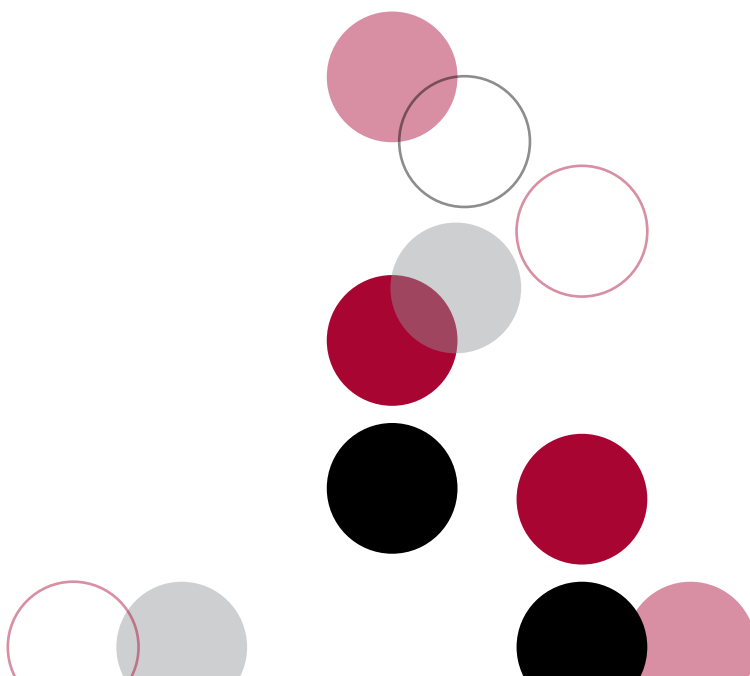
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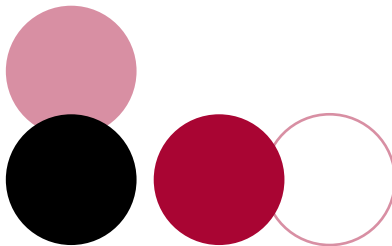
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INTRODUCTION & BACKGROUND

David J Hunter

One of the many prevailing fashions in health policy, at least as far as England is concerned, is for joint Director of Public Health (DPH) appointments. The notion is not a new one and there are examples of joint posts which have existed for many years with varying degrees of ‘jointness’ although their experiences have not been well documented. But what is new is the push for such posts to become the norm across the country where circumstances such as co-terminosity in respect of NHS and local government boundaries permit. Where they do not then other solutions will be required. It is certainly not a case of ‘one size fits all’.

It was the former public health minister, Caroline Flint, who was especially keen on the idea following a speech at the Faculty of Public Health’s conference in 2006 and who subsequently encouraged their introduction. Her belief, shared by many others working in public health, was that joint posts were ‘a good thing’. Possibly they are but why and in what ways are for the most part, and in the absence of firm evidence, the subject

of conjecture and speculation. Certainly the idea has not been subjected to critical scrutiny and analysis. This is the purpose of this publication which the IDeA Healthy Communities Programme has commissioned from Durham University.

The booklet’s centrepiece is a critical appraisal of joint Directors of Public Health (DsPH) by Tony Elson which is accompanied by a number of invited commentaries derived from his analysis. The contributors were selected to represent different stakeholders and/or sectors of public health policy and practice. They were invited to comment on Elson’s perspective specifically from a local government viewpoint.

Some recent history

From 1974, when certain public health responsibilities were removed from local government and transferred to the NHS, until recently, with the arrival of joint appointments, the DPH has been an executive member of the health authority. This has given rise to tension between the NHS and local government because, as Elson (1999: 163) puts it, 'many people in local government believe it is their organisations, rather than health authorities, that are public health authorities'. Joint DPH appointments are therefore an attempt to resolve this tension and are a recognition, not new in itself, that improving health and tackling health inequalities cannot be the preserve of the NHS acting in isolation.

There is a major role for local government as part of its 'place shaping' responsibilities. The case was accepted by the House of Commons Health Committee in its inquiry into public health conducted between 2000 and 2001. It was most recently restated by the Local Government Association's Health Commission when it noted that local

government's public health role stems from 'its responsibility for many of the services that play a role in determining a population's health' (Local Government Association 2008: paragraph 5.6, 84). Indeed, some would go further, insisting that local government is the natural leader for public health and that its lead role should never have been removed from it in 1974.

Such arguments were brought to the fore when the Parliamentary Health Committee deliberated the future of public health. The Committee was especially struck by evidence given by Dr Andrew Richardson, holder of the first joint NHS/local authority post in Solihull. He worked out of council offices and had chief officer status within the council. In his view, 'the location of DsPH at the heart of the NHS has inevitably pulled them away from, rather than towards, those parts of the wider system that most powerfully influences health'. He felt that DsPH needed to be 'eased out of the NHS box' and that 'joint posts might help to place the DPH closer to the centre of the web of responsibilities, budgets,

skills, interest and power that can impact on health in their locality' (House of Commons Health Committee 2001: paragraph 163, I). Many other witnesses also voiced support for joint DPH appointments and the Committee itself regarded them 'as a positive measure' and believed there should be 'a presumption in favour of joint appointments'. It was critical of the Department of Health for being insufficiently proactive in the matter although, as noted, this is no longer the case.

Although from time to time there have been calls for a major reallocation and restructuring of responsibilities for health which would give local government the lead role, there are few enthusiasts hell-bent on ushering in a further round of major change. Even the parliamentary Health Committee, which in principle favoured relocating the public health function to local government, conceded that there could be 'no return to the past' and that a further major structural upheaval was not in anyone's interests. Certainly those in the NHS, having been subjected to endless waves of change in recent years and with many suffering from 'reform fatigue', would need considerable persuading that further structural change or reallocation of responsibilities was the answer.

At the same time, it is recognised that while the NHS has an important role in secondary prevention and in keeping people well, there are limits on how far it can or should stray into the wider determinants of health. Its core business is not seen to lie there and while confusion and uncertainty remains, then the role accorded public health within the NHS is likely to remain similarly confused and uncertain. Evidence for this may be seen in respect of the absence of agreement over what public health is or whether a set of shared values can be said to underpin it (Hunter 2008). No wonder the Chief Medical Officer for England in his 2005 annual report bemoaned the weakness of public health as manifested by the ease with which resources allocated to it found their way into offsetting deficits in acute care budgets. He concluded: 'this situation has not been created by any person or group of people. It is the result of many disparate factors, but at its heart is a set of attitudes that emphasises short-term thinking, holds too dear the idea of the hospital bed and regards the prevention of premature death, disease and disability as an option not a duty' (Department of Health 2006). In short, the challenge is a cultural one in a healthcare system that continues to put treating illness before promoting health.

In the face of the equivocal evidence it received on whether a transfer of public health to local authority control would be the right thing to do and outweigh any disadvantages accruing from further upheaval, the LGA Health Commission, perhaps wisely, chose to adopt a halfway house. While not ruling out radical change, it recommended an incremental approach. Where initiatives were already underway in which local authorities were taking a leading role in relation to public health, 'there should be freedom and scope for pilot studies based on the transfer of some Primary Care Trust (PCT) public health responsibilities to local government, where there is local agreement to do so' (op cit, paragraph 5.63: 93). It seemed likely that pooled budgets and joint commissioning would be the hallmarks of such an approach.

An exception to the lack of published commentary on those joint DPH posts which have been around for some time is Redgrave's description of his experiences in Barnsley (Redgrave 2007). He notes the considerable variety in arrangements and degrees of 'jointness'. This can include 'joint funding of the DPH post, a strong commitment to joint policy making and co-operation' (p. 227). But lesser degrees of integration exist. In order for a joint post to be successful, Redgrave insisted

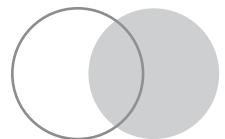
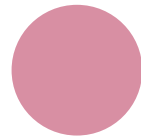
that a level of enthusiasm within the local authority to tackle health issues was essential but he also believed that, notwithstanding the biases and difficulties cited above, the PCT must also 'focus more upstream on health as well as downstream on healthcare' (p.227). The upshot of such thinking is a need for a shared set of values to which local authority officers and members and PCT boards can sign up. Redgrave is also at pains to stress the need for joint DsPH to have both the 'political awareness and ability to operate outside their "comfort zone"' (p.228). Those appointed must be prepared 'to lead, challenge, persuade, cajole and influence', recognising that they will more commonly have an important influencing role rather than a direct management one. Such insights are echoed in Elson's piece and the accompanying commentaries which follow this introduction.

For Redgrave, and others, the most important factor in making joint posts work is the level of understanding in both organisations about the role and function of public health. Yet, being clear about these has proved troublesome as a recent scoping study of the public health system in England has shown (Hunter et al 2007).

The LGA Health Commission notes the variation in how jointly-appointed DsPH operate and calls for clearer guidance to be provided. Based on the experience of the Cheshire and Merseyside Partnerships for Health (2006), it goes on to make a set of recommendations. Key among these are the following:

- the joint DPH should be at the most senior level in both the PCT and local authority, with dual accountability to the two chief executives
- the DPH is a member of both senior/chief officer teams
- the DPH's duty and freedom to express independent views is guaranteed
- it is agreed how much time the DPH will spend with each organisation
- it is agreed what resources each organisation will contribute.

However, even if all these recommendations are accepted and implemented there remain important issues concerning how the DPH should conduct themselves and what types of roles and expertise they should aim to bring to the joint appointment. As Elson points out, there cannot be a 'single nationally defined role for a DPH' that is 'likely to work in all settings'. But the skills and experiences of each individual DPH are critical to success. These issues form the main focus of this booklet.



The contributors

The five contributors cover a wide range of stakeholder interests both in public health and in the role of joint DPH appointments. The brief was open-ended. Each contributor was sent Elson's paper and invited to base their contribution on the issues raised. There was no direction given as to which issues they should address, only a suggested length of commentary. In the event, although they were not obliged to engage directly with Elson's arguments virtually all did so. Without exception, the contributors welcomed the debate and the six models of practice around which it is structured. Some intend using it in their internal discussions to guide the future evolution of the joint DPH post.

Responses to Elson's perspective

Before drawing out some of the key issues the contributors identified as critical to the future success of joint DPH posts, it is perhaps of significance to note what they chose not to comment on. There was little reaction to Elson's 'background to change' section. Yet the context surrounding the arrival of joint posts in many local areas and the politics of such a policy, are surely important and of considerable interest and not just for students of public policy. For local government, noted for its independence, it appeared that joint DPH posts were presented as the solution to a health inequalities problem and that they should therefore be introduced forthwith. Hardly surprising, then, that the complex issues to which Elson draws attention were left to be resolved in a serendipitous fashion on the ground, and important issues concerning how the role of the joint DPH would fit into long established and complex organisations may not have got the attention they deserved.



Without exception, and perhaps not at all surprising, the contributors are unanimous in their support for the principle of joint DPH appointments. The two contributors from local government – Steve Weaver and John Beer – both claim that the DPH has contributed significantly to the health-related work of their authorities. Former NHS chief executive, Neil Goodwin, goes further and sees the future for public health as residing with local government and not PCTs. In his view, joint DPH appointments are merely a step along the road with ‘eventual merger’ as the end point. Nick Hicks, a joint DPH of five years standing, does not go this far although he regards it as ‘entirely reasonable’ that public health practitioners should ‘aspire to leadership roles within local government’. Both Goodwin and Hicks consider the joint post from an NHS perspective and agree that having a foot in both camps is desirable if real progress is to be made. For this to be possible, senior management support across both organisations is vital.

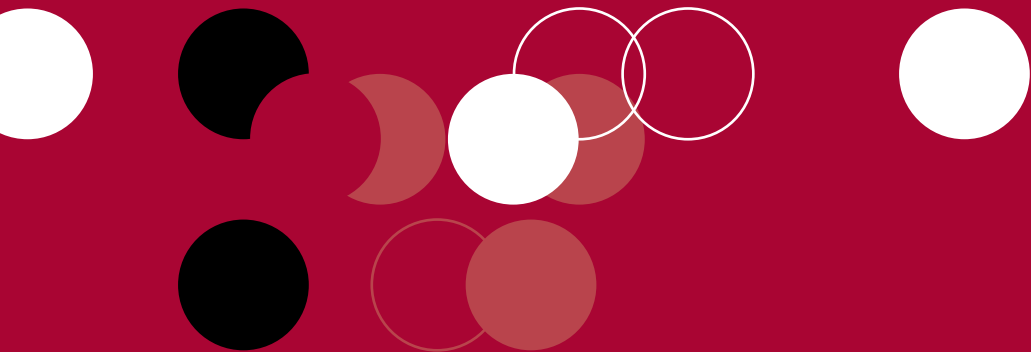
But if joint DsPH are to perform effectively, they must possess the requisite skills and expertise. Catherine Hannaway, from her leadership development standpoint at the Improvement Foundation, considers these issues and finds them wanting. Even where the issues and deficits in skills and expertise are acknowledged, there remains a dearth of appropriate programmes to meet the leadership and development needs of DsPH in joint posts. Consequently, some struggle with the complex culture and organisational diversity they have to make sense of and manage. Derived from Elson’s six models, there is a need for a set of core skills. Most important among these are, in Hannaway’s words, ‘political astuteness and aligning cultures and performance’.

Conclusion

If there is a single key message to take away from this review and assessment of joint DPH appointments, it is that although they may in principle be ‘a good thing’, much unfinished business remains to ensure that they are both viable and effective and can add real value when it comes to meeting the objectives of public health, whether national or local.

In its consideration of joint DPH appointments, the LGA Health Commission notes the wide variety of organisational arrangements and the absence of systematic and independent study of their impact and effectiveness. It calls on the Department of Health to commission an evaluation of the various models over the next three years. Such research is needed and it is hoped that the issues raised here in this booklet might contribute to the agenda for research that is needed. But in a fast-moving environment, three years is an eternity to wait for useable results. There is a pressing need for understanding and insights that might yield useful lessons at a much earlier stage in the evolution of joint posts and can perhaps influence their future shape.

The analysis and set of commentaries published here is no substitute for such a study. But research of this nature inevitably takes time and events are moving swiftly. The need for a critical look at joint posts and how they can be strengthened so that they deliver for key stakeholders – principally the NHS and local government – is urgent and cannot wait. If the views expressed by the contributors give pause for thought and result in a more informed discussion about what joint DPH posts can achieve, and in what ways, then this publication will have more than fulfilled its purpose.



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JOINT DIRECTOR OF PUBLIC HEALTH APPOINTMENTS – 6 MODELS OF PRACTICE

Tony Elson

The scope of this paper

It is an accepted wisdom that joint appointments to the post of DPH are a good thing. The majority of areas now have joint DsPH and have benefitted from their ability to advocate and link up issues across a locality. However local differences mean that joint appointments work in different ways around the country, this article attempts to look at these varied models of operation and the ways in which joint DsPH contribute to the day to day management of a local authority.

In 2006 PCTs boundaries were rationalised and central government made it an objective for all upper tier councils and their respective PCTs to make joint appointments. National guidance was given for making them and since then many new appointments have been made. It seems a useful point to reflect on how these arrangements are working, considering both areas of strength and for potential improvement, in order to maximise the impact and achievements of joint appointments.

I acknowledge the benefits that can be achieved if joint appointments work well. Local partners would be foolish, however, to assume that making the joint appointment alone will address health inequalities, we know from a range of evidence that a much more sophisticated approach than that is required. What matters 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.

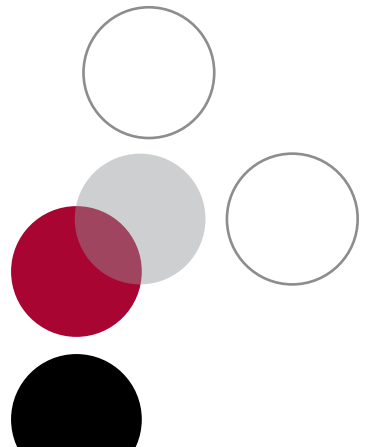
This paper is written from a local government perspective for a local authority audience, but will also be of interest to health service colleagues. It is very much based on my own reflections and opinions as an ex-local authority chief executive and adviser to the Department of Health. It concentrates on the role that a joint DPH might perform for the council. The primary audience are councils where the arrangements are not working well or where the council has not yet considered whether the post is delivering its potential. Where arrangements are working well, it may still help to stimulate thinking on the way posts may need to change in the future.

It looks at how the DPH works with the separate political executive and scrutiny roles in councils. Most local government senior managers will have extensive knowledge of the tensions that arise from serving both parts of the council. DsPH have often joined councils with very little experience of working in this kind of political environment. The paper explores the subtlety around professional and strategic

leadership of health improvement work. The nature of the contribution that the DPH makes to the decision making structures of the council must be clear. It argues that as local authority structures, cultures and processes differ widely across the country, no single nationally defined role for a DPH is likely to work in all settings.

The skills and experience of the individual DPH and the operating environment within the council are important to success. Joint appointments are difficult as PCTs and local authorities are very different organisations. Those who hold these posts need to establish exceptional personal credibility to be successful. The personal skill 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.

In this paper I describe a variety of different roles that may be performed by a DPH. I present these as models of practice that are artificial but are intended to demonstrate the strengths and weaknesses of each approach. I make no judgement as to which model works best. This is for local partners to determine. Readers will be able to see which model is closest to their current arrangements and consider whether a different one might be better.



Background to change

Before exploring the models, it is worth reflecting on some of the background to the establishment of joint DsPH, as this provides a useful context for the models that follow.

When the government developed its guidance for joint appointments the situation varied across the country, in some places voluntary joint appointments had been made whilst in others this was not a local priority. The government guidance gave the impetus for more joint appointments but in some cases local commitment to the post was mixed, one might argue this was an inevitable local reaction to a national policy decision. The position was not helped by the fact that many PCT boundaries were being reorganised at the time, which meant that there wasn't always capacity for really meaningful discussions between local partners about the role / remit and reporting lines of the joint DPH post, and led to the restriction of the recruitment pool.

This left some DsPH without a clear work programme or expected outcomes and with suggested reporting lines to the local authority chief executive which did not always help to foster good relationships with other council directors who felt they had more budgetary and service responsibilities within the authority. This experience of establishing credibility amongst those with more budgetary and service responsibility may be a little different from the DsPH experience in their own PCT.

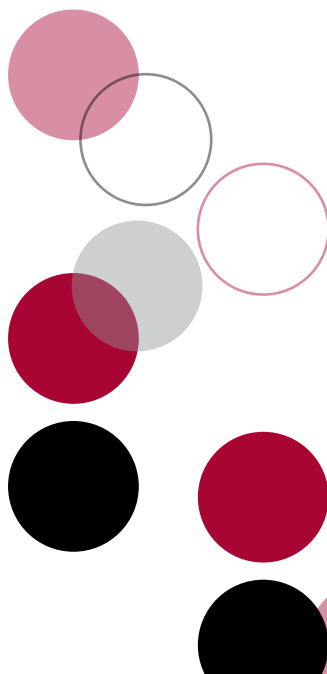
This varied picture around the country has led to the evolution of a number of different models of practice which reflect individual skills and local circumstances. It could be argued that these operating arrangements have not always been driven by a strategic decision to support the delivery of health improvement objectives. However it can also be said that adapting the post to local circumstances allows for useful variation and a model to develop which fits where the authority 'is at' with health improvement issues. This is what I hope to explore through the following models.

Models of practice

This section will describe key factors characterising six models and will describe in outline the characteristics of the local authority that will best suit this particular approach. The models are:

- the expert
- the critical friend
- the adviser
- the provider
- the catalyst
- the community advocate and leader

The models are not mutually exclusive. Considering the proportions of time spent working in different models of practice may be a useful way of thinking about which model is dominant in a particular joint appointment.



The expert

Characteristics

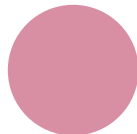
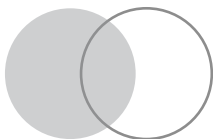
This joint appointment is the in-house information expert. The DPH will be a skilled statistician who is aware of levels of health and sickness, and is able to correlate these with measures of affluence and social disadvantage across the area, mapping them using scientific and objective methodologies. The emphasis is on facts. This DPH may have less regard for attitudes and opinions and little understanding of the views and motivations of local politicians or those of local people.

Commentary

This role is a legitimate one. It sets a baseline for action, but the responsibility for action lies elsewhere. The purity of the model comes from the scientific objectivity of the post holder, and the concentration on producing a balanced picture of need for the locality.

Local authority best fit

The local authority must have capacity to understand the material presented and develop policies to create change. It will have a track record of drawing on an evidence base for effective health interventions. Health improvement and tackling health inequalities will already be strong priority for the leaders in management and councillor roles. There will be strong management systems in place and resources to develop action plans that lead to real impacts on the health and well-being of the area.



The critical friend

Characteristics

In this role the DPH will have an understanding of the facts about the health of the community, together with an understanding of the health impact of different policies and service delivery models. This information is used constructively to challenge the status quo and suggest ways in which the council can improve its health improvement performance.

Commentary

This role is well established across the country. DsPH have often attended scrutiny committees, and presented their annual reports on the state of health in the area to the council's political and managerial executives. The DPH will be used to review council plans and policies and will make suggestions for change that maximise health benefits. Crucially, there is little or no personal accountability for delivering change. The DPH is firmly independent of the executive leadership of the authority and can speak with professional freedom.

Local authority best fit

There needs to be a leadership at both managerial and elected member level that is aware of health issues and motivated to listen. The authority will have a strong and effective scrutiny function which examines health improvement issues. Their deliberations will influence future priorities. Information and decision making processes will be open and inclusive. This model can enable elected members who are close to their communities to become well informed health champions, using messages provided by the DPH. The model will work less well in a confrontational political culture.

The adviser

Characteristics

This jointly appointed DPH is part of the executive support to the political and managerial leadership of the authority. The main difference between this role and that of the critical friend is one of accountability. He or she will go beyond advising on what should be done to helping to reach conclusions about what can be done within available resources. This may make the DPH less able to speak out as the independent expert. The scrutiny committee may on occasions hold the DPH to account for progress in areas of his or her responsibility.

Commentary

This role offers more direct influence than the expert or critical friend as there is significant involvement in the decision making process. There is opportunity to argue for approaches that maximise health improvement. This influence comes at a price of having to take some form of collective responsibility and publicly support decisions once made. The DPH will rarely be able to circumvent this by claiming professional privilege and independence.

Tensions may arise as a consequence of the joint nature of the appointment. For example the PCT may have expectations that the DPH will push certain priorities that the council executive does not wish to pursue.

Local authority best fit

This model will work best where there is an understanding of the health improvement agenda and a willingness to support it in policy development and operating practice. Ideally this should be both at political and managerial leadership levels, although it can work where only the management team is committed. The management and political culture needs to be a reasonably open one, with appropriate forums for debate. The model will probably work most effectively in councils without a very confrontational political tradition that seeks to exploit and polarise differences in opinion.

The provider

Characteristics

The significant feature of this model is that the DPH has taken on significant operational management and budgetary responsibilities within the council. Usually, although not always, it is restricted to staff involved with work that has a clear impact on health promotion.

Commentary

The model can offer an opportunity for the DPH to demonstrate operational best practice. Mainstream services such as social welfare housing and environmental health have historic links to health in local authorities. Social and economic regeneration areas also have obvious links. These can be drawn together with NHS services such as health visiting and school health to create an integrated provider service. From a PCT standpoint this model raises some difficulties for the DPH's involvement in strategic commissioning because of the recent emphasis in the NHS is on the separation of commissioning and provider functions. There is less emphasis on separation in local government but there is some tension between senior managers who see themselves as service providers and those who are seen as part of central support function.

Local authority best fit

This role will be familiar to those local authorities where senior managers hold service responsibilities alongside a contribution to corporate strategic planning and development and may be helpful in strengthening the perceptions of the importance of the DPH role. It may also be helpful in authorities that struggle with capacity at senior level. Sharing the burden of managing service delivery can create space for new initiatives in areas like health improvement.



The catalyst

Characteristics

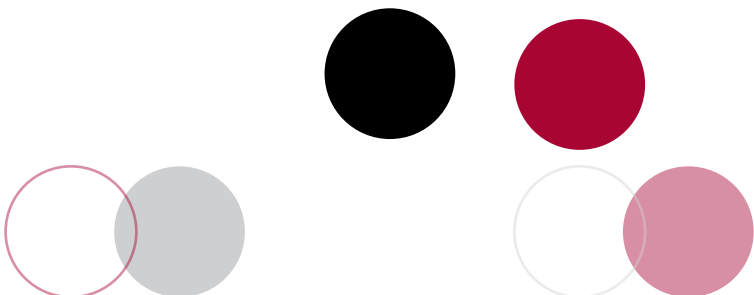
The focus of this model is on maximising the benefits of partnership work. The DPH will use the role to develop trust and a shared understanding across two very different organisational cultures. The technical expertise will still be there but the balance of time will be weighted towards networking activities.

Commentary

A DPH well versed in both cultures is well placed to facilitate shared understanding and effective partnership working. The role can also be influential in bringing in other partners in work to improve health and narrow health inequalities. The strength of the role may come from being slightly independent of the two employing agencies, especially in bringing in other public, private, voluntary and community group partners. Where the catalyst role is successful the partners will develop a commitment to working together towards a shared purpose.

Local authority best fit

To give scope for this model partnership will not be working particularly well but there will be a recognition that it is worth cultivating. Key leaders must be prepared to work with the DPH to improve relationships and will accept health improvement and addressing health inequalities as part of their agencies' areas of responsibility.



The community advocate and leader

Characteristics

The professional expertise and independence of the DPH is at the heart of this model. He or she speaks for the disadvantaged and advises the wider population on health issues. In doing this, the DPH may develop a substantial public profile, sometimes becoming better known than the council leader or chief executive. With the high public profile comes the potential for controversy and opposition from individuals and groups who do not share the DPH's analysis.

Commentary

Historically, there are a number of examples of DsPH who have acted as the conscience of their communities in this way. The annual report of the DPH which usually receives publicity in the local media, can be seen as part of this role. There are no real parallels for this role within local government management. Elected members, who are increasingly encouraged to see themselves as local community leaders and advocates, would be the nearest equivalent. There are dangers and difficulties in this model, most obviously where the action being advocated is counter to the council's policies or priorities. Politicians are not comfortable with people, who are seen as at least in part council employees, criticising council actions or decisions. This can be more of an issue when controversial views become associated with the council and reflect on its reputation.

Local authority best fit

There has to be a political and managerial culture that will tolerate expert opinion, even when critical of the council. This will be coupled with a reasonable degree of respect for the professional skills and impartiality of the DPH. An established culture that respects and understands the differences between management and political roles will be helpful, as will a supportive chief executive. Written protocols that define the DPH's operating space may help. It will not work well where there are significant political differences between groups on the council as the DPH's opinions will be used to fuel these debates.

Outcomes

The process adopted by the NHS for making joint appointments focused on the job description and organisational arrangements but placed little emphasis on outcomes, the presumption being that the skills and abilities of the DPH alone would achieve benefits. There may have been an expectation that once in post the DPH would negotiate a set of outcomes that would frame a work programme. Anecdotal evidence from conversations with key players backed up by more objective evidence from

such sources as the reports on council performance on health improvement drawn from the latest Comprehensive Performance Assessment programme suggest that this has not always been the case.

Taking a more strategic approach to what needs to be achieved, box 1 illustrates how practice might be described in terms of input and outputs required. It uses the 'expert' DPH role and assumes that the right support is available from the council to make use of this role.

box 1

Input by DPH (the expert)	Output from DPH	Key inputs needed from the council	Local authority output	Outcomes for local people
High level of analytical skill. Knowledge of illness and threats to good health.	Detailed technical reports mapping the facts about the incidence of ill health within the area.	A senior member or officer motivated to provide leadership for health improvement work. A strong planning culture which can use data to good effect in service planning and policy formulation.	Services which are more closely targeted on specific health needs of defined groups within the local population.	Improvement in health of the target group; a narrowing of health inequalities for these groups.

A proper assessment of performance in improving health and narrowing health inequalities is possible only where the council has a clear view of the measurable improvements in health that it is seeking to achieve. Too often discussions at local level describe outcomes in process terms rather than in ways that demonstrate the impact on people's lives.

An unintended consequence of the recent focus on Joint Strategic Needs Assessment is that it can encourage this way of thinking. The pull on a DPH to get overly involved in such initiatives can be strong. Producing reports and advice about what needs to be done can become the mission, rather than delivering the changes that lead to measurable health improvement and the reduction of inequalities.

It is often unclear where overall leadership for health improvement lies. Many professionals working in the field simply assume that it lies with the DPH. As is clear from the different models of practice above, the leadership contributions from the DPH are varied. Many councils also fall into the trap of thinking that the appointment of a professional lead in the form of a joint DPH removes the need for other strategic leaders to give health their attention. However, if sustainable change is to be achieved, overall strategic leadership for health needs to be in place and understood by all.

It is not simply a question of the council saying that the DPH has sufficient authority and support to improve performance in this area or signalling this by arranging for the DPH to report direct to the council chief executive. In most cases there will be a need for active involvement by other key managers in changing the systems that have the potential to deliver health improvement and they will set their priorities to reflect the messages they receive from their political and managerial leads. The health improvement programme will have to be delivered alongside and sometimes in competition with other council programmes and priorities.

The level of strategic leadership of the agenda exercised by the DPH will depend on how involved he or she is in the council's key decision-making processes. High involvement is not essential to success as long as others such as the chief executive, council leader or an executive director take on the role. However, it is vital that the DPH's responsibilities are well defined and that where the strategic leadership lies is understood by all.

Whoever has responsibility for the strategic leadership of the change agenda for health must decide to use the DPH in particular ways to strengthen aspects of the delivery system. For example, where there is a low understanding of health improvement issues, a 'critical friend' model DPH may be desirable to raise this. Where there is understanding within the council, and a requirement to take the messages to the community, a DPH in the 'community leader/advocate' model will look more attractive.

In each case the work programme and outcomes set for the DPH will be different. These outcomes can be described as process or intermediate outcomes that contribute towards the council's overall goal which will be expressed in terms of direct health impact on the lives of local people. They can be defined and have measures and timescales set. Achievements will not automatically lead to a measurable impact on health but the DPH and the whole management team should be clear on how the contribution fits into the overall plan for health improvement.

Box 2 looks at examples of intermediate outcomes using the earlier models and how these might be measured.

Model	Examples of intermediate outcomes
The expert	<ul style="list-style-type: none"> • Better informed priority setting. • Improved performance management through more effective measurement of progress.
The critical friend	<ul style="list-style-type: none"> • Wider awareness of health improvement needs and the problems of health inequality in the area amongst councillors/staff. • A growing understanding of the way that council services can have an influence on the health of the community.
The adviser	<ul style="list-style-type: none"> • Integration of health improvement objectives into the council's mainstream service planning processes. • A culture where challenge exists to test the health impact of any significant changes to policy or practice.
The provider	<ul style="list-style-type: none"> • A specific service delivery plan for the area of responsibility that the DPH manages that models the way that the council is contributing to health improvement and a narrowing of health inequalities.
The catalyst	<ul style="list-style-type: none"> • Improved inter agency partnership working around health improvement and health inequality issues.
The community advocate and leader	<ul style="list-style-type: none"> • Raised public awareness about the health challenges facing the area and the contribution that individuals, civil society and the public sector make to health improvement.

Examples of some indicators of success

- Evidence of the use of data to determine which activities of the council are supported with increased resources.
 - More overt targeting of services on those in greatest need.
-
- Increased frequency of debate and discussion within meetings of the council and its committees.
 - Requests for further information and analysis.
 - More recommendations from scrutiny to the political executive on actions that will support health improvement.
-
- An increase in the number of column inches devoted to health improvement within other council service plans.
 - An overall service plan for health improvement that describes how health inequality will be tackled by the whole council and includes a realistic resource plan.
 - A record of action that has been taken as a result of health impact assessment of new policy and practice developments
-
- The delivery plan will include S.M.A.R.T (Specific, Measureable, Achievable, Realistic and Timebound) targets for improvement of health in chosen sections of the population.
 - Measurable evidence of progress derived from the performance management system developed to support the service plan.
-
- Practical evidence of an increase in the dialogue that takes place between agencies around this topic.
 - An increase in the confidence and respect that key people have in the partnership structures locally.
 - A subjective assessment, by key actors, of the extent to which relationships and trust between agencies are improving.
 - Agreement of a shared vision and agreed set of priorities.
 - Clarity about where leadership of the agenda lies within individual agencies.
-
- An increase in the number of column inches / media interviews on health improvement and health inequality given over time.
 - Numbers of people reached through attendance at meetings and public events.
 - Feedback from user groups on the way that their understanding of health issues has changed as a result of this work.
 - Practical examples of individuals or groups who have changed behaviours as a result of the input from the DPH.

Skills, knowledge and abilities

There is a relationship between the intrinsic skills, knowledge and abilities that a DPH possesses and successful performance in different models of practice. No single individual will be excellent in all areas, so it will be a question of the best balance and local 'match'.

Technical expertise in public health

Knowledge of health and illness and the statistical relationship between lifestyles and health disadvantage is essential to all who work in this area. Some individuals will have wider knowledge and more advanced technical expertise than others. Well developed skills in this area are particularly important to the 'expert' model.

Other key areas of expertise particularly affect performance in a local authority setting.

Political sensitivity

This attribute is needed at the most senior levels of management in local government. It is wider than 'party political' sensitivity although an understanding of how party politics works within a council is essential to survival. More broadly, this skill is one of anticipating where controversy lies and managing the potential organisational and individual threat it may pose. The 'nanny state' controversy is one example of the current dangers faced by DsPH. Awareness of political cycles is important. Taking a stance which leads to public criticism in the media just before an election is an example of a lack of this skill!

Communication

This is always looked for in candidates for top posts but it can find different forms of expression. Sometimes people are good at presenting complex health arguments in ways that are easily understood by policy makers. Others are commanding speakers capable of addressing a variety of audiences and changing people's attitudes. Communication skills need to be matched to the kind of role envisaged for the DPH.

Negotiating and influencing

These skills are more essential in some roles than others. They would be key in the 'adviser' model. They would also be valuable if the organisation is less than enthusiastic about the appointment of a DPH, where many years of work may be required to establish a credible and effective role.

Change management

Many councils hold these skills in high regard in top level appointments. Some DsPH may have more difficulty in demonstrating skills in this area than their local authority management peers. Career structures in local government often present more opportunities for managers to cut their teeth in significantly sized operational roles early in their careers and selection processes may require evidence of successful change management before an appointment is made.

Problem solving and finishing

These skills are generally regarded as essential for any top council management appointment. In some local authorities the stereotypical view of the way DsPH approach their work is that they are good at defining problems and poor about doing anything about them. The skills of problem solving and completion are most needed in the 'adviser' and 'provider' models.

Leadership

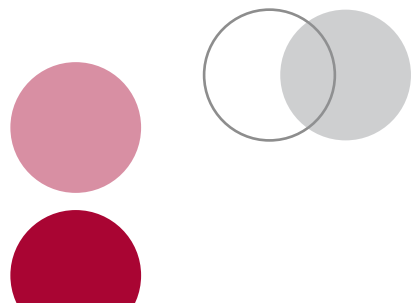
Leadership is at the centre of most management texts and leadership skills are always written into job specifications for senior management posts in local government. The skills listed above would be seen by many as aspects of leadership. There are different styles of leadership which can be adopted. The 'community advocate and leader' model would require a more overt style than is necessary for an 'adviser' or 'catalyst'.

There will be a difference in the leadership skills required to set the vision and direction for an organisation and those required to deliver the implementation of a programme of work.

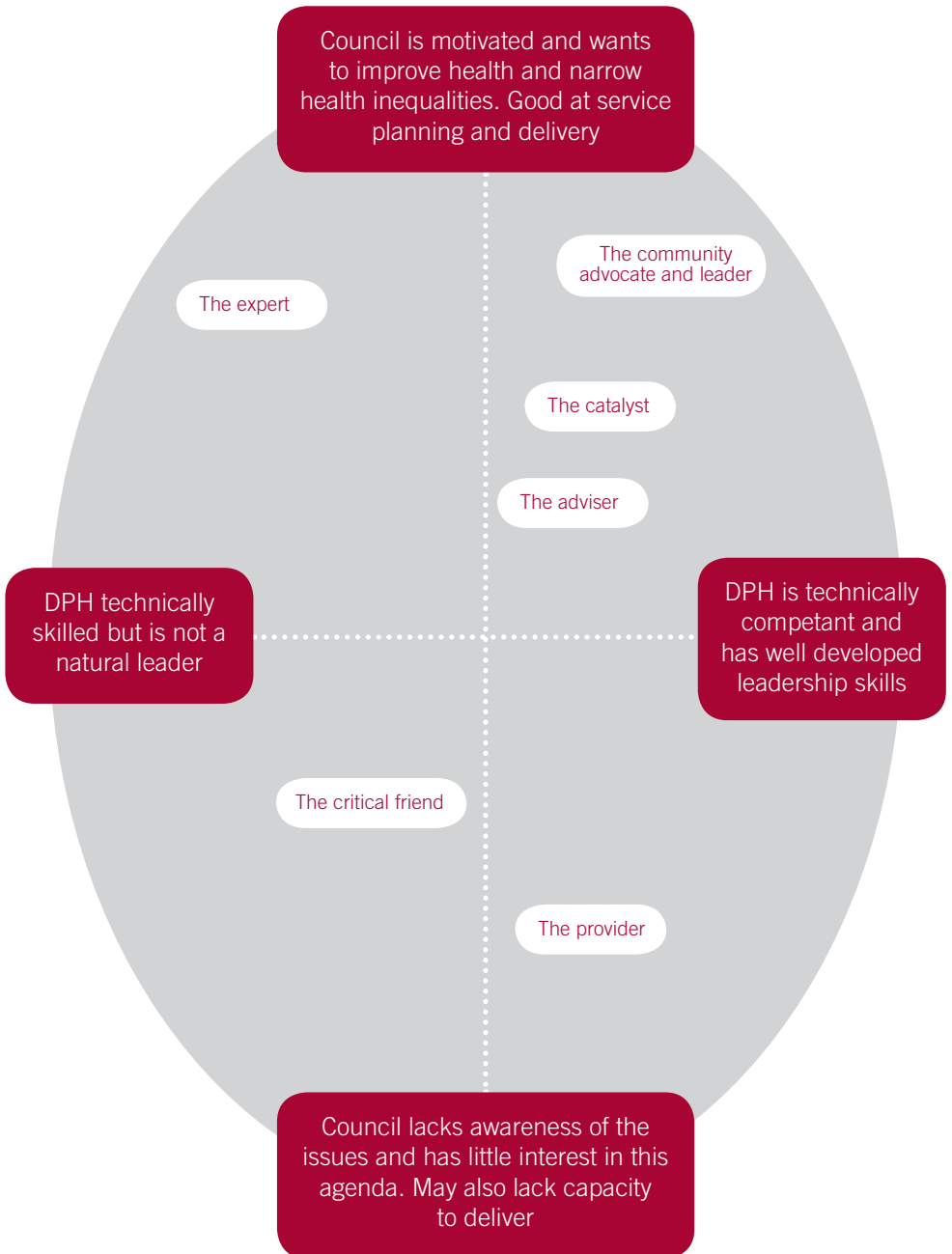
Best fit

Individuals will hold skills in different proportion. When filling posts in the real world, organisations have to look for people who have the best fit of skills to the outcomes set. Individuals will have what may be termed a 'comfort zone' in which they can most easily operate, where the skills held most closely match the attributes that the job requires.

This paper presents a case that the council's current state of development and culture will dictate the model of DPH most likely to be successful. This section highlights the skills that may align with the models. These lines can be drawn together to illustrate the likely best balance between the organisation and the individual, the 'comfort zone' as shown in the following figure.



Matching people and organisations



Conclusions

It is right to end by restating the potential benefits that a joint appointment can bring to a local authority's work on health improvement. It could be said that a joint DPH appointment may be a necessary condition for making significant progress but in isolation it is not sufficient to deliver this outcome.

The main message of this paper is that there needs to be transparency about how the post is to be used. This must start with an appraisal of the roles needed. It should not be an arbitrary decision or one taken reactively in response to the skill set that a DPH brings to the post. The role has to be matched to the needs of the council, reflecting:

- local history
- the political and management culture of the organisation
- the commitment to the health improvement agenda
- organisational structures
- relative strength of partnership working
- the external environment

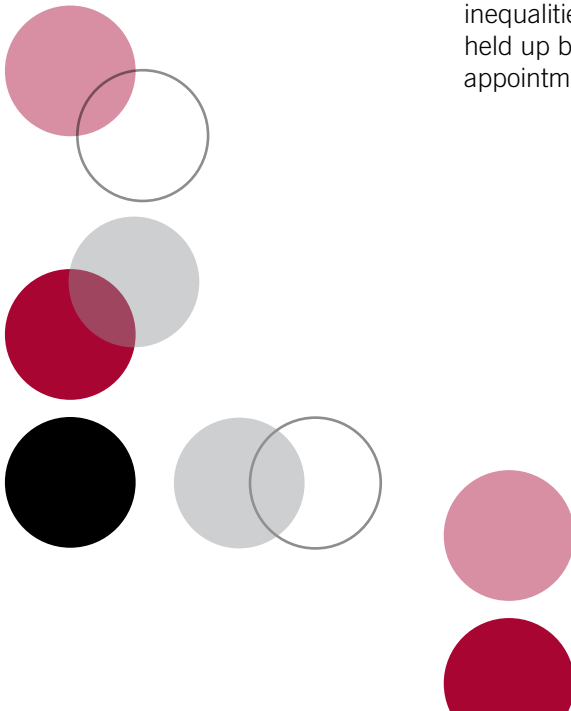
The nature of the post is likely to change over time. This implies that in order to maintain an effective match between the skills of the DPH and changing models of operation, their personal development and where necessary succession planning will need to be addressed.

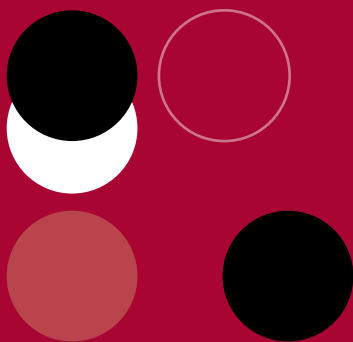
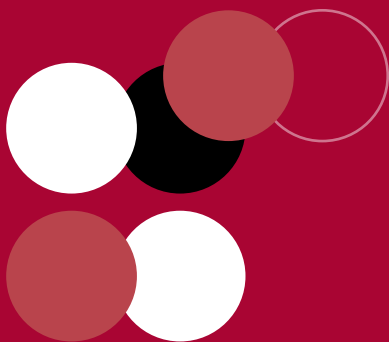
My models are simplistic and designed to polarise debate in order to highlight the different skills that are needed and help the council reflect on the match between the approach the DPH is being asked to adopt and the supporting environment.

I have focused on what the joint appointment can bring to the local authority. In practice, the partner PCT will also have expectations which will influence the DPH's use of time and the kind of role to be undertaken. In focusing on what the council wants from a DPH the intention is to stimulate an informed debate, which may involve disagreement, rather than acquiescence with an appointment process led by the PCT working to a traditional NHS brief. I feel the best use for the paper is as a starting point for local discussion, perhaps first within the council and later with partners.

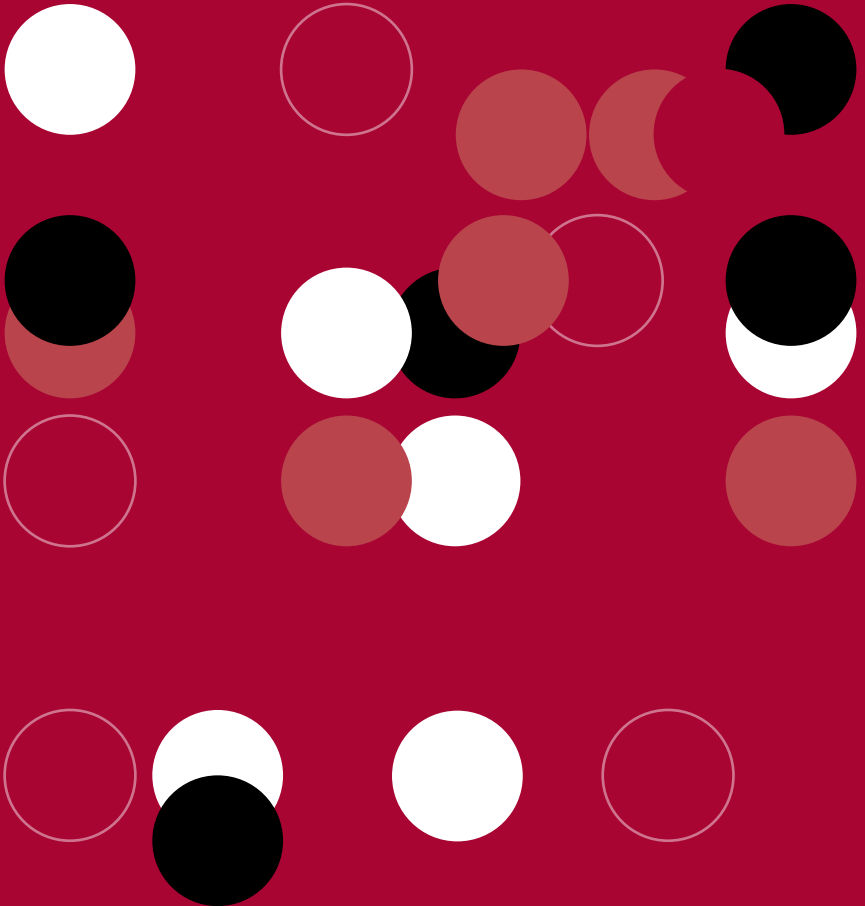
Where appointments already exist, organisations should think whether any of the models describe the predominant work programme of their DPH and if so whether the model matches local needs. The analysis can also be done the other way round by first considering the needs of the council and then cross checking to see how closely the DPH is addressing these. If the match is poor, the question that must then be addressed is what to do about it. This may lead to difficult discussions in the short term.

My experience in working in local government for 35 years is that success will not be achieved without addressing difficult situations. The challenge of health improvement and health inequalities is too important to be held up by an ineffective DPH appointment.





REFLECTIONS ON
ELSON'S MODELS OF PRACTICE



A PERSPECTIVE FROM BLACKPOOL

Steve Weaver
Blackpool Council

Blackpool is a relatively new all purpose authority formed along with Blackburn with Darwen Council as a unitary council in 1997, emerging from the previous two tier arrangement within Lancashire County Council. Its population is around 142,500 and it has very constrained boundaries with the adjoining district councils of Fylde and Wyre.

Blackpool is still Britain's most popular seaside resort with an economy largely based on service jobs both directly and indirectly related to the visitor economy and the public sector. However, it has experienced steady decline in visitor numbers over several years and although there are radical plans to reposition the resort through major regeneration the impact of these plans will not be seen for a number of years.

The consequence of this decline and the highly urbanised nature of the built environment have seen Blackpool exhibiting major social and economic problems similar to those in scale and akin to the impact of the inner cities. The extent of these problems is such that on the last published Index of

Multiple Deprivation, Blackpool is placed as the 12th most deprived local authority in England.

Amidst the array of statistics that illustrate the scale and depth of deprivation, none stand out more than those related to health. Blackpool has the second lowest male life expectancy and highest alcohol related deaths in England, with very high levels of teenage pregnancy, male suicide, and obesity. Health is therefore high on the agenda for the Council, the PCT (which has a co-terminous boundary with the Council), the acute and mental health trust, and the local community. It is no surprise, therefore, that health is a key priority both within the sustainable community strategy and Local Area Agreement (LAA).

The role of DPH needs to be viewed in this context. I would say that the DPH has contributed significantly to the prioritisation of health across the public and third sectors and to the development of a range of cross-cutting and creative initiatives to tackle these serious health problems.

Tony Elson's paper offers an interesting analysis of the various roles that a DPH can adopt. Of course, in reality, every DPH must adopt a mix of all of them.

Why can we say that the DPH role in Blackpool was successful?

The DPH became a 'well-known' position in the Council as a focus for all things that were health-related. It sits in the wider senior management team, which meets informally every week for an exchange of information and networking (this comprises principally around 30 of the key first, second and third tier officers within the Council). As a result of this the DPH became well known in other partnership and community environments – probably much more so than if the role had just sat in the PCT. Additionally, the PCT chief executive along with the divisional commander of police sits on the directors team of the Council, ensuring that the joint DPH post operates in a real partnership environment.

A joint role gives much more access to wider opportunities than may be traditionally considered. In Blackpool's case this has involved direct involvement in the masterplan for the resort and in particular leading on the social impact of the proposed casino development.

By creating an environment whereby health and wellbeing rose to the top of many partnership meeting agendas and internal discussions, many people working in the Council felt able (or were 'liberated') to bring ideas for health improvement to the table for discussion. This has worked especially well with the Council's leisure services and has resulted in many exciting new prevention initiatives – and added real value, synergistically, to the work of the PCT and Council.

A key element in turning the priority given to health in the sustainable community strategy and the LAA's, has been the transformation of aspiration to action through a series of negotiated agreements, principally between the PCT and the Council. The successful negotiation of

these was greatly assisted by the DPH acting as 'honest broker' enjoying through his joint role the confidence of all parties delivering challenging but achievable change and actions through measurable improvements.

These early wins have been critical in the joint post being seen across all bodies as a credible leader for public health in the Council and across the Local Strategic Partnership.

Key to this joint post working is that it must have support at the most senior level and in this case from the Chief Executive and Leader of the Council, both in regard to including the DPH in the officer senior leadership group and engaging with the political leadership directly as well as through scrutiny. Through this arrangement, strong personal relationships were established across the Council and not just through adult social care and children's services. And also this direct access and involvement has enabled the DPH to be taken more seriously by other agencies.

Alongside issues of structure and 'buy in' is the critical one of culture and clearly there are significant differences between the NHS and local government culturally. To operate in both with joint responsibilities and be credible and effective is not an easy challenge. Whilst this is

helped by the above and further helped by the depth of joint working, commissioning and appointments between health and the Council the skill set to be a good DPH is extensive and it will always be difficult to identify and recruit good candidates recognised as such when dealing with two quite different organisations both locally and nationally. This applies even when faced with the same client groups and issues on the ground.

A DPH will only function above Tony Elson's 'expert' role when they have an expert public health team behind them. It is near impossible for a DPH to function at any effective level in the council and wider partnerships if there is no-one back at the ranch to do the basic epidemiology, needs assessment and provide support to commissioning.

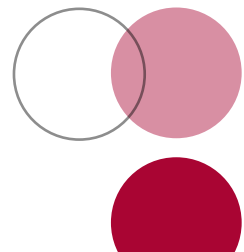
In relation to the 'provider' role, there is more to be explored here, especially in respect of the possibilities in enhancing credibility and building relationships with the potential to manage provider services such as environmental health. At the same time, it would be crucial not to lose the strategic role of the DPH or credibility of its position within the NHS. A joint DPH needs, in addition to their role in the local authority, a very clear understanding of their role in the PCT. The chief executive of the PCT must also have high levels of trust in the DPH and the limits of delegated authority must be clear.

Pragmatism should be the key rather than prescription – in terms of day to day (or month to month) line management of a DPH I think it is fine for the DPH to fit into the structure of a local authority as appropriate, i.e. managed by a strategic director but direct access to the chief executive and political leadership is important.

The possibility of transferring public health responsibilities to local authorities and moving the role of DPH from the PCT to the LA has been proposed in some quarters. There are many pros and cons to this proposal and it is worthy of separate discussion. However, I doubt if there is a 'one size fits all' approach. On balance, I believe the DPH role as it works in Blackpool currently

is fine – but a great deal depends on the person and the people, officers and members in the Council and in the PCT to make it work. More time perhaps should be spent thinking about how we prepare someone to be a DPH – what should the training be? Perhaps the training should include spending time at more junior levels in policy / strategy / performance departments or even some secondment time in a range of operational services.

More fundamentally, wherever the DPH sits if he or she is to respond appropriately to the very different needs of localities then the role should be sufficiently loosely defined to allow local partners to create the DPH that is needed for their area.



REFLECTIONS ON BEING A JOINT DIRECTOR OF PUBLIC HEALTH

Nick Hicks

Milton Keynes PCT and Council

Five years ago I was appointed as a joint Director of Public Health by Milton Keynes Council and Milton Keynes Primary Care Trust. This paper sets out some of my thoughts about:

- the reasons why a public health practitioner should want to work in a local authority (LA) and why a LA might want to employ a public health professional as part of its leadership team
- the factors that can help make a joint DPH post effective.

I compare and contrast the issues I identify with those identified in Tony Elson's framework. I am aware that my conclusions are influenced by my experience of working in just one authority and, as councils vary enormously, readers will have to judge whether or not my conclusions are relevant to their own settings. I am also aware that there are many different ways to approach the practice of public health – and I don't claim that the approach and attitudes that I adopt are necessarily better or more effective than others.

Why a public health practitioner might want to work in a local authority and why a local authority might want to employ a public health practitioner

In common with most public health practitioners I regard health as being multi-faceted involving much more than the absence of physical disease. This is neither a new nor controversial idea, for example, the ancient Greek, Pericles, defined health as:

“ that state of moral, mental and physical well-being which enables a person to face any crisis in life with the utmost facility and grace.” Pericles (495 to 429 BC)

Pericles's multi-dimensional conceptualisation of health has stood the test of time. It has much in common with the World Health Organization's more recent and widely quoted definition of health:

“ a state of complete physical mental and social well-being and not merely the absence of disease and infirmity.”

These broad notions of health underpin Acheson's much used definition of the practice of public health as:

“the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society.”
(Acheson 1988)

These broad definitions of health and public health practice have been accepted and promoted by the LGA (LGA Health Commission 2008). Accepting these broad definitions has important implications. For example, it follows directly that the determinants of health are many and varied. Indeed, these broad definitions make

it possible to claim that almost every aspect and circumstance of the ways in which we live our lives and of the ways we choose to organise our societies may be considered as having an impact on health and the distribution of health in our communities. As the actions of local government influence many aspects of local life it is unsurprising that public health practitioners committed to improving health and reducing inequalities in local communities should want to influence local government. There are many ways of influencing an organisation, but one of the most powerful can be to work for the organisation in question, especially if it is possible to contribute to its leadership. As a consequence, I believe it is entirely reasonable for some public health practitioners to aspire to leadership roles within local government.

But just because some public health professionals might aspire to leadership in local government, does not mean that local government will necessarily want to employ them. Before taking on a public health professional, councils need to satisfy themselves of two things:

- that – as an organisation – they believe local government can and should work to improve the health and reduce health inequalities in their communities
- that employing a public health professional among the council's staff and/or leadership will add value to the council by helping it have a greater impact on health and health inequalities than it otherwise would.

If a council can answer “yes” to both these questions and it then considers the possibility of appointing a DPH, a third question a council should ask is whether they will get better value from employing a DPH jointly with the NHS or from an equivalent professional working exclusively to the council i.e. what is the value of making a joint appointment?

Does local government believe that it could and should work to improve the health of its communities and reduce inequalities within the community?

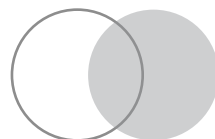
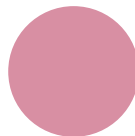
Increasingly, more and more councils believe that the answer to this question is “yes”. This is reflected in the position taken by LGA Health Commission (LGA 2008) – and with good reason.

Good health is highly valued by the vast majority of individuals and communities. There are few people and organisations who do not feel some sense of responsibility to protect people's health and most would be pleased if their actions demonstrably improved and enhanced health. Local government has a long and proud history dating back to the 19th century for championing health. Arguably, in recent decades – particularly after the loss of the post of Medical Officer of Health in 1974 – many authorities' focus on health has waned. In my experience, many councils, councillors and local government officers would now like to re-establish local government's leading position as a champion and agent for public health. However, although councils are increasingly keen to fulfil a public health role, they are not always confident, about which policies and actions they should

pursue that are likely to make the greatest difference to health and health inequalities.

Many of the councils that have come to see themselves as having a significant public health role have welcomed the Department of Health's initiative to establish DsPH in England. But as Elson suggests local commitment to the post was mixed 'an inevitable local reaction to a national policy decision'. For those DsPH who, find themselves appointed to a post in a local authority with limited commitment, a first task for the post-holder must be to establish support for both the role and the post-holder among at least some influential members and the senior management team. I would suggest that if it is not possible to create that support, it will prove very difficult for a post-holder to be effective.

In my own case, a council cabinet member and the Chief Executive of the Council were members of the appointment panel that appointed me. I learnt later that the Council would not have gone ahead with their half of the appointment if they had not had confidence in the individual appointee. Although not everyone in the Council understood why the Council had appointed a joint DPH or knew what a joint DPH would or should do, there were advocates for the DPH role and for me as an individual among both the cabinet and the corporate leadership team. Without such support it would have been very difficult to be effective.



How can a DPH working for the council add value to the work of a local authority?

The only reason for a council to employ a DPH is that it believes that they will add value by increasing the beneficial impact the council will have on health and health inequalities in its local communities. Such an outcome cannot be taken for granted as the evidence would suggest that a joint DPH is neither a necessary nor sufficient condition to achieve health improvement. For example, health - as measured by expectation of life at birth - has improved dramatically by some 30 – 40 years in most developed countries during the course of the 20th century regardless of whether local government has employed senior public health professionals. But, although being neither necessary nor sufficient, I believe strongly that an effective joint DPH working in the right local government environment can add value and can help a community's health improve faster and more equitably than would otherwise be the case without such an appointment.

Key characteristics of such an environment include:

- support for the post and post-holder among at least some of the political and managerial leadership of the council
- a position in the organisational structure for the joint DPH that gives the post-holder access and authority to influence across the full range of decisions that are likely to impact on health
- competent support for the DPH to enable a continuous public health presence in the authority (as a joint DPH will inevitably spend time in the NHS and elsewhere).

Other factors that help include simple geographic relationships between the NHS and local government with the simplest being a unitary authority co-terminous with a PCT, and a council that is good at developing policy and that has the necessary machinery and ability to implement policy effectively.

So, assuming there is at least some support among the leadership of the council for the role and post-holder, what are the factors that make it more likely that a joint DPH will be effective?

Motivation and agenda setting

I believe that the post-holder needs to form their own view and to build a related understanding that is shared as widely as possible about:

(a) the health issues faced by the community

This is a crucial first step. In my experience the simple demonstration of the substantial differences in expectation of life between electoral wards, and demonstrations using local data of the strong association between socio-economic disadvantage and poor health have proved extremely motivating to councillors of all political parties.

(b) the nature of the interventions are likely to make a beneficial difference to health and health inequalities

It is important DsPH move beyond identifying problems and propose solutions.

(c) what the council can do differently to accelerate and deepen its impact on health and health inequalities

Among the interventions that are identified, it is important to be as specific as possible about what the council can do – acting both alone and in partnership with others – to make a difference to health and health inequalities.

These roles correspond closely to the roles that Elson describes as “expert”, “critical friend” and “adviser”. I believe that they are all necessary for an effective public health function in local government. That does not necessarily mean that the DPH has to undertake the analyses and presentations personally, but he or she does need to satisfy themselves that these roles are being undertaken in the authority. For example, in my own case I contribute to the understanding of local health issues through my annual report and more recently with the Director of Children’s Services and the Director of Adult Social Services through the Joint Strategic Needs Assessment. Also, working with the Environment Directorate’s information team, I supported the production of a detailed social atlas and catalysed and championed the creation of the Milton Keynes Observatory. These documents and tools together provide a rich and detailed picture of demography, socio-economic and health issues faced by Milton Keynes and a view of how the needs of the community are likely to change in coming years.

Influencing decision making

Understanding the health needs of the population and explaining what could be done to address them is not enough for things to change. Decisions, backed by the necessary resources and effective implementation, are required if anything is to change. If the post holder is to influence decision making s/he will need a clear understanding of the distribution of power in the council and a detailed understanding of the mechanics of the decision making processes of the authority.

If the DPH is new to local government this is likely to require much new learning. In my own case I was fortunate to benefit from the advice of the Leader of the Council and the Chief Executive. But even so, it took me a while to appreciate the strength and significance of the relative autonomy of the major directorates of Milton Keynes Council and to learn that working from the corporate centre was often not the best way of influencing key decisions within directorates. My impact increased once I was able to build better access to the directorate management teams by linking members of my NHS funded public health team to each of the council's main directorates.

Community leadership is an important role for local government. Councils can have a significant influence on the behaviour of other organisations through mechanisms such as the Local Strategic and other partnerships and the development of the sustainable community strategy and Local Area Agreements (LAAs). The DPH can harness this influence to increase their effectiveness. Locally, as a community in Milton Keynes, we chose to focus the whole second generation Local Public Service Agreement (LPSA2) – the precursor to LAAs – on social inclusion and health inequalities. This led to substantial investment in a wide range of multi-sectoral activities to tackle multiple manifestations of health inequality including issues such as dental health of poor children, smoking, employment for people with mental health problems, and educational failure in poor areas.

These decision influencing roles of the Council based DPH do not map directly onto Elson's framework – although there are elements of them in the “catalyst” and “community advocate and leader” roles that he describes. He also touches on decision making when describing the skills, knowledge and abilities a DPH requires to be effective. Personally, I think the ability to operate and influence in large and complex organisations is an essential pre-requisite for an effective DPH.

Structure and position in the Authority

The issues I have identified above have implications for where I think a DPH best fits in a council's structure. As I believe the DPH should seek to influence a wide range of policies and decisions across the Council, I think it is important that the DPH has access to corporate, rather than just directorate, decision making and policy making. I think this is most easily achieved if the DPH reports to the chief executive and is a member of the corporate management team. That in turn implies that the DPH must be prepared to share collective corporate responsibility and to play a full role in corporate decision making. Personally, I believe that it is important the DPH makes a full contribution to corporate decision making. For any DPH who believes, as I do, that it is mainstream corporate activity – and not just activity badged public health – that is the way organisations have the greatest influence on the public's health.

Capacity

Much of what a DPH needs to achieve can, at least in theory, be done by working through teams employed and managed by others – for example a council information team. There is a limit, however, to what can be achieved without a team working directly to the DPH – particularly if the post-holder is a joint appointment with significant responsibilities in the NHS which means they spend much of the week away from council premises. I believe that it is important that there is a continuous visible public health presence in local government and that there are people who can be relied upon to represent and promote the views, values and advice of the DPH to multiple groups within and across the organisation. It is therefore essential that the DPH has at least a small team to support them in their work in local government.

I agree with Elson, that direct service management can make it easier for a DPH to be accepted as an equal by those who manage large services but that it is not essential to being an effective DPH. I also agree with Elson that if and when the commissioner / provider separation becomes clearer in local government the value to a DPH of directly managing significant services is likely to diminish further.

A joint DPH or a council only DPH?

One question that Elson's framework does not address is whether there is added value in making the DPH appointment jointly with the NHS. A case can readily be made that there is enough work in the council alone to support the appointment of a DPH that works exclusively for the council. But I believe that failure to make a joint appointment would mean missing out on the opportunities that a joint appointment brings. In my experience, being a joint appointment brings real benefits to both the NHS and the council. For example, although Milton Keynes has a reputation for good partnership working, I still find that as a member of the management teams of both organisations I can help speed information flow between the organisations and help interpret one to the other. Being a joint appointment with influence in both organisations really does make it easier to align objectives, targets, measures, timetables and managerial processes. The 'jointness' of the appointment short circuits many discussions and allows collaboration between the organisations to develop faster and deeper than I believe would otherwise have been the case. I believe the easy alignment of LAA objectives with full incorporation of relevant Council LAA targets

into the PCT operating plans are good examples of this deep collaboration. I don't claim such things could not have happened without a joint appointment, just that they are easier to achieve with one.

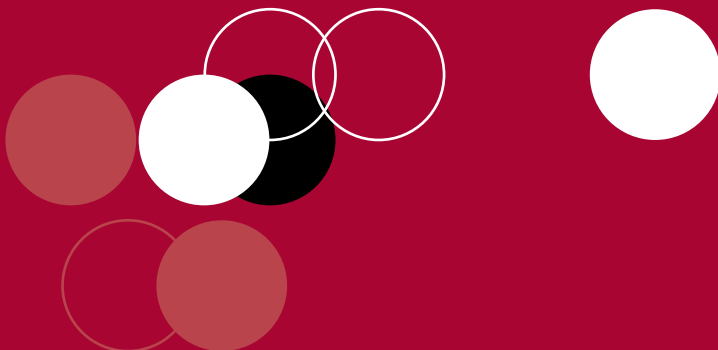
Conclusion

To conclude, I believe that jointly appointed DsPH working in the right corporate environments have the potential to bring considerable improvements in health and health inequalities to local communities. I also believe that Elson has described a very helpful framework that councils and post-holders can use to help them get the most from a DPH. I will certainly use his framework with my Council and NHS colleagues to consider how we can better strengthen the contribution, and that of me and my team, to the health of the people of Milton Keynes.

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PUBLIC HEALTH FROM A LOCAL AUTHORITY PERSPECTIVE

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In Southampton we established the post of joint Director of Public Health in 2002 and have used this to help the City Council develop its understanding of public health and its promotion. This paper analyses the outcomes of the arrangement.

As a Director of Adult Social Services (DASS) I have the statutory duty to promote health and wellbeing. How this is done varies from local authority (LA) to LA but the focus given is partly dependent on the health inequalities evident in the LA area. This is often very evident in city, unitary and metropolitan authorities. In Southampton people die on average seven years earlier than those who live in the neighbouring New Forest.

When I first started reading the annual report of the DPH it seemed to be commenting on all the issues that featured in the health inequality in our city. Also many of them were relevant to the causes of social problems which produced 'customers' for social services. It was these realisations that made me promote the idea of a joint appointment and choose

to part fund the post. So now, six years later, has my aim and the LA funding improved the health of the city?

Those of you who know the role of the DPH and how it is viewed in the NHS will be aware that it can be a very lonely and at times frustrating task. Waiting times and deaths from major diseases carry more votes than the health of the poorest people, and the DPH and the annual report may make an interesting read but not translate into action to narrow the 'health gap'.

Even if action is taken it may take many years to turn it into a measurable change in life expectancy, e.g. smoking cessation, and other wider factors such as an increase in binge drinking, may work against anything that might be achieved locally.

However, if the DPH is the conscience of the NHS in Southampton he is also the conscience of the LA. He is now a member of the chief officer management team, a trusted voice on our health scrutiny

panel, and a major contributor to regeneration. But does a conscience change anything in the behaviour of a LA, any more than it does in the NHS?

Value of DPH role

From a DASS point of view I have found the role of DPH to be invaluable in changing attitudes within the LA towards promoting health. We were in the forefront in banning smoking within the council and in public places. The information and support from the DPH were vital in this: but our planners never agreed to a large 'quitters' poster on the side of the PCT head quarters.

Dental care in Southampton is poor but we are moving fast down the route of considering fluoridation in our water supply and in particular the support of health scrutiny as advised by the DPH has encouraged the Strategic Health Authority (SHA) to start the process of public consultation on fluoridation.

Teenage pregnancy is a significant issue and although progress has stalled, initial early improvements were driven by the work of colleagues in public health.

Alcohol abuse is a major problem for the city and the DPH by being a trusted 'insider' in the city council has helped to shift attitudes from 'all development is good for the city' to serious views about how access to alcohol should be controlled. As ever, data coming from public health demonstrate the problem and gives a baseline to measure progress.

Another area where the benefit of economic development has been queried is in the promotion of gambling. The debate is not over but the DPH persuaded politicians to consider whether the benefit in terms of jobs and taxes was worth the damage caused by, and health and social costs of, addiction and possible links to organised crime.

The Joint Strategic Needs Assessment recently published in Southampton is truly a joint effort, led by the DPH and it will determine the city's health and social care priorities for the next five years.

It would be wrong of me to create the impression that the City Council is always able to respond positively to the views of the DPH. Smoking cessation was initially hampered by the concern about jobs in our tobacco factory, and some of our members and our trade unions were opposed to curtailing the liberty of people to smoke (an issue now overtaken by wider legislation).

Relevance of the different roles

Looking now at Tony Elson's paper I think his analysis of the various possible roles a DPH may perform is both illuminating and daunting. Although he is clear that they are not mutually exclusive, nevertheless his six different key aspects, which I think are all valid, can perhaps explain why there may be a lack of precision about how the joint appointments own effectiveness can be measured.

In Southampton our DPH is an acknowledged expert supported by facts and figures that are the envy of less well organised professions. By dint of his style and semi-independence, he is accepted, and used, by the corporate management team as a 'critical friend'. But whereas various members of the team hold statutory roles which give them the authority to say 'You can't do that', the DPH has to stay as

a 'friend'. Furthermore, as Tony Elson points out, advice can be used in varying ways in a political environment. One should not underestimate the skills senior LA officers have developed to walk this minefield, and hence the line management of the DPH on the LA side is critical.

The 'advisor' role, as delineated by Elson, is, even more challenging. The DPH might be expected at times to assume a share of corporate responsibility and present a joint front externally. I'm not sure the DPH can always subscribe to this and retain clinical integrity.

There is much to commend in the 'provider' role not least the DPH having responsibility for staff to help cover the very wide range of meetings a joint appointment is expected / requested to attend in the LA. Managing 'health development' in the LA makes sense: indeed, in these integrated times, why would you not? If the LA is contributing half of the DPH salary, surely the PCT should be investing that bounty in joint appointments to promote health and wellbeing, not buying more acute episodes. I wonder how much of this latter has occurred?

Tony Elson's point about the tension of managing both commissioning and provision is well made. Pure models have been tried in the past –

compulsory competitive tendering being a prime example, where to make it work two sets of managers were needed. It is not clear that the extra cost involved produces better service outcomes. LAs have become used to the paradox of commissioning and providing, and as the NHS moves to ever greater separation we must avoid the need to have two DsPH – one to say what should happen, and the other to provide it.

The ‘catalyst’ is a role that any joint appointment must fulfil at times. In the challenging arena of partnership working, roles which foster trust and understanding are always helpful. However this role highlights the position of the DASS who will have previously (in most LAs) had the lead for this task. The role of DASS was blurred when it was stated that the DPH report to the LA chief executive and has further impacted upon the relationship between the PCT chief executive and the DASS which is now moving to be more of a relationship between the PCT chief executive and the LA chief executive. How does the DASS relate to these emerging relationships? It seems to me that these are issues that need to be resolved in each LA area. They are too sensitive and variable to be directed from the Department of Health.

Finally the ‘community advocate and leader’ is a role that DsPH will not want to relinquish. It will give them a place in the public eye but if we are to ameliorate health inequality, why should we regret this?

Conclusion

If a joint appointment does not bring added value, then why do it, particularly if the role of the DPH to promote the public health is compromised? The health of those who lack the resources or knowledge to be as healthy as those who have both resources and knowledge would not then be a prime focus. This will at times be challenging to politicians and senior executives. If the DPH is to remain the champion of promoting good health for all, whatever local arrangements are achieved, it must be accepted in the LA that DsPH should stay outside of compromises that fetter their core role.

AN EXTERNAL PERSPECTIVE

Neil Goodwin

GoodwinHannah Limited

Introduction

Tony Elson's paper has much to commend it. His analysis and views will add considerably to the ongoing debate about the accountabilities of PCTs and local authorities in leading and delivering health improvement.

However, this response argues that in considering the ideas and proposals in Elson's paper greater account needs to be taken of the interpretation and impact of local context, including the relationship between the top management of local authorities and PCTs; and the personal development requirements of DsPH if joint appointments are to be successful.

National context

There are two contextual points that I contend are important in considering Elson's arguments. First, delivering public services is becoming ever more challenging when they have to be positioned in an environment of increasing consumer awareness, the stimulation of which has been a key public services policy approach of national government over the last decade. One implication of this increasing consumer focus is the need to have clear leadership as part of the process of enhancing public accountability. This is because paying greater attention to leadership necessitates, among other things, establishing effective relationships with stakeholders such as consumers. Compared to the NHS, and partly because of its underlying democratic processes, local government has a stronger history of establishing relationships with external organisations and stakeholders,

Second, the inexorable direction of travel for leading and commissioning health and health care is from PCTs to local government. The joint

appointment of DsPH is merely one step in the direction of ever closer working, and eventual merger, between the two sectors. The arguments for, and benefits of, transferring responsibility for healthcare commissioning to local government tend to focus on addressing the democratic deficit of the health service, enhancing the integration of health and environmental issues in commissioning, reducing bureaucracy and so on.

To these arguments is sometimes added a wish to return to what are seen as the halcyon days of medical officers of health – those independent, robust and visible leaders of public health of yesteryear. Given the health challenges facing society today perhaps the desire to return to what is probably seen as a time of clearer leadership and accountability is not an unreasonable wish.

Elson is right when he indicates that it is not the symbolism of the appointment that is important but how it is used. He is further correct when discussing the various role models in a

reflection of the importance of understanding local relationships, which are an integral part of local context. The NHS has been slow to understand the importance of local context in leadership, management and the implementation of strategy. Historically, too much detailed strategy and implementation planning has been determined nationally but perhaps the Next Stage Review (led by Lord Darzi), with its emphasis on a regional approach to strategic development, offers the best opportunity to create a more sustainable approach to change. Time will tell whether this will be better than the historically centrally-driven approaches of the last decade.

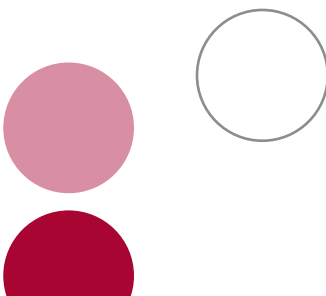
Another message that could be taken from the approach of the Next Stage Review is concerned with the organisational development of the NHS. National government, of whatever hue, needs to accept that there is limited scope for further regional and local development of the NHS until it moves away from consistently rooting its approach to change in the hierarchical

structure established in 1948. Perhaps it is making a start with the Next Stage Review and moving in the same direction as the decentralised structure of local government. As the term indicates, the emphasis in local government is on local leadership and strategy played out against the backdrop of national policies. For the NHS, which has some way to go to achieve the same position, the jury is still out on whether hierarchical and regulated systems operating together are compatible and, in addition, whether they will enhance managerial capability and capacity across the NHS.

Local context

Research on the role of chief executive-led management teams of NHS commissioning organisations clearly indicates that understanding context is crucial to delivering successful leadership (Goodwin 2002, 2005). Context, which is both local and national, provides vital motivation and relevance to people. Above all else, people at work want to know 'why', so the ability to interpret and explain what is happening in the external world is a powerful and influential personal quality. Consequentially, the ability to interpret national context into local meaning is a frequently under-rated and underdeveloped leadership skill. And what differentiates the great leader from the merely good is the ability to translate national context into local understanding for implementation planning and delivery, so that people can implement policies and targets in the way they do business locally. This is particularly important for those in leadership roles spanning different organisations, which adds to the complexity of undertaking business locally (Goodwin 2007).

As local government amply demonstrates, its focus is on tackling issues that are seen as important to local people and stakeholder organisations, rather than solely implementing national government policy. It is



this emphasis on being seen to tackle issues of local significance that will differentiate the local leader. Of course, this will often include distilling national policy into locally understood and implementable plans but local leadership is about going further, and perhaps faster, in addressing local challenges not falling under the umbrella of national policy. Health improvement would be a good exemplar of local leadership driven by local context.

In practice, understanding local context necessitates, among other things, analysing and categorising the history of the development of local relationships. Elson reflects this in his paper when he says, 'The (DPH) role has to be matched to the needs of the council, reflecting local history, the political and management culture of the organisation...the relative strength of partnership working, the external environment.'

Developing public health leadership

Elson is correct when he indicates that understanding the agenda and contextual health improvement challenges facing the local authority needs to be clearly articulated and accepted by the political leadership as a precursor to appointing the director of public health and determining his or her priorities for

action. However, there is a much broader and fundamental issue to take into account, which is the quality of the relationship between the leadership of the council and the leadership of the local primary care trust.

This is important because it is senior management that establishes the tone, style and culture of working, not only within organisations but also inter-organisationally across health and local government systems. We frequently forget that it is people - not whole organisations or departments - who actually do business with other people. Consequentially, if the leaders of organisations within health and social care systems fail to establish good interpersonal relationships, or if there is a wide divergence of views on local strategy between the organisations, then the appointment of a joint director will be doomed to failure from the beginning.

Implicit in the skills, knowledge and abilities required of a DPH, particularly political sensitivity, communication, negotiating and influencing and leadership, is possessing emotional intelligence. This is the practice of using thinking about emotions to guide behaviour. The cornerstone of emotional intelligence is self-awareness, namely the ability to see and understand ourselves as

others see us. Self-awareness, along with career experience, is the key to the development of personal wisdom and maturity as well as coping with, and learning from, failure. All leaders will have experience at failing but great leaders will not only bounce back from disappointment within days but they are also clear about the resultant learning points. Finally, with wisdom and maturity comes leadership humility – the subsuming of personal ego for the greater good of the organisation.

Developing self-awareness is easier said than done but without it, the development of personal leadership skills is virtually impossible. However, evaluation of a senior leadership development programme for directors across NHS West Midlands, which includes DsPH, shows a number of personal learning outcomes for self-awareness (Flanagan et al 2008). Clarity of leadership role and its impact in the workplace, personal self-assurance, insights into personal strengths and weaknesses, development of new interpersonal skills and enhanced influencing skills were just a few of the benefits gained by participants.

The development of self-awareness is also important because it provides the basis for directors to step back from their day-to-day lives and reflect thoughtfully on their managerial and leadership experiences (Mintzberg 2004). In other words, personal development learning is not doing – it is reflecting on doing. However, reflection is not a casual process: it about wondering, probing, analysing, synthesizing, and connecting to one's inner-self. It is necessary to think not just about what has happened but why it has happened and how the situation under reflection is similar and different from other issues. More specifically, some commentators argue that when reflecting on our roles and actions in situations, we should reflect first and foremost on our strengths because this is the most important thing for the successful executive to know about themselves (Drucker 2005).

In the light of the above it should be no surprise that also valued by participants on the West Midlands programme was coaching and mentoring support because this helped translate the learning into meaningful reality for participants. And networking between participants, partly structured through action learning, provided the opportunity to share and reflect on personal leadership experiences. This is important because leadership

can be a lonely business so being able to share experiences with others in a safe and confidential environment is often a welcome opportunity, arguably even more so for directors whose role spans organisations with different cultures.

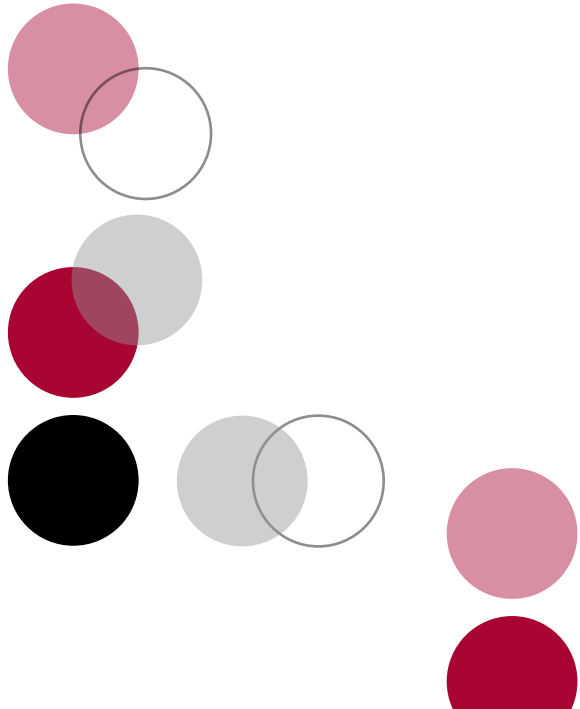
If the above approach to personal development is accepted then there are at least two ramifications for public health. First, compared to most other branches of medicine public health has to operate on an inter-organisational basis to be effective and successful. And the basis for effective inter-organisational working is good quality interpersonal relationships. This calls for leadership and personal skills development to be an integral part of the postgraduate training curriculum for public health professionals and should be assessed in the same way as other components of the public health specialist training process.

The second ramification is that leadership and personal skills should be assessed when matching potential appointees to the requirements of the director post at the time of the appointment. Of course even if the role starts with the least sophisticated of Elson's six models (expert and critical friend) it is likely to become more sophisticated as the relationship between the local council and

primary care trust develops. This is most likely to be generated from inter-organisational confidence in tackling local health challenges, which in turn will require the personal skills of the director at least to develop at the same rate. If directors can develop faster than their principal organisations and thereby achieve greater improvements in health status then they will be exercising leadership. Consequently, directors need to be appointed with the potential to develop their personal style and impact, thus making the assessment of self-awareness a crucial part of the selection process.

Conclusion

Tony Elson has produced a thought provoking analysis that deserves serious debate about how best to implement the model of the joint NHS-local government DPH. This response is intended to add to Elson's analysis by emphasising the need for greater consideration of analysing local context and the training and development of leadership and personal skills during postgraduate training and following the appointment of joint DsPH.



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THE DPH ROLE FROM A LEADERSHIP PERSPECTIVE

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Introduction

Joint DsPH appointments are a good thing. As Tony Elson highlights in his paper, joint appointments should bring real benefit since they are aimed at strengthening joint working to improve the health of the population, tackle health inequalities, and support the development of services for local communities. However, there is still much to be done to ensure success across the country rather than just in isolated pockets. It is also the case that joint appointments alone will not drive the partnership agenda. In addition, strong leadership skills, well developed partnership working, shared reporting and governance arrangements as well as pooled budgets must underpin the effectiveness and success of these new arrangements.

The proposed models of practice

The six models of practice Tony Elson proposes for discussion provide a sound description of some of the possible roles and essential skills, experience and capabilities that a DPH in a joint post needs in order to operate effectively. They offer local councils the opportunity to develop deeper understanding of the best match between their organisation and the skills and interests of a DPH, and possible ways that they might wish to develop the relationship they have with their existing DPH in order to get most benefit from the appointment.

Whilst a focus on one model over another is undoubtedly important depending on the culture and requirements of each local council, what is of most significance is that the DPH has a well grounded ability to work with all these models, and the awareness to understand when and where different skills and styles of working are required in order to be able to adapt accordingly. Matching the skills of each DPH with the council(s)

s/he is employed by makes sense (as in any job), but a set of core skills would ensure that DsPH are able to work in all of the models described by Elson as being important.

The model for understanding ‘situational leadership’ styles by Hersey and Blanchard (2007) describes the willingness and ability to look at a situation and assess others’ development needs in order to decide which leadership style is the most appropriate for the goal or task at hand. Similarly, an ability to assess a situation and be agile enough to be able to respond with the appropriate skills is required by DsPH in order to be most effective. The competencies and skills required must either be present internally within the team, for example, in the form of strong operational management support, as in Elson’s ‘provider model’, or through understanding the need to work in close partnership with others who can support the DPH in the ‘expert model’. It is unlikely that one individual could be highly skilled in all of the areas identified in the six models, but being strong in only one style of operating,

matched closely to the local authority working in that mode, would be very restrictive.

The sub-sections that follow look in more detail at the proposed models for a joint DPH appointment.

The expert

The characteristics of expertise a DPH should possess, as described by Elson in the ‘expert model’, would form an essential part of the set of core skills required by all DsPH. A key factor for consideration is that the DPH is transferring their skills, networks and expertise into a new organisation, where other sources of expertise may already exist, for example information and data sources. It is an important role for the DPH (as in the ‘catalyst model’) to use their expertise to maximise the benefits of partnership working by bringing together these often disconnected information sources and ensuring they are valued.

Other characteristics of a DPH described in the ‘expert model’ suggest that a DPH whose strengths lie in being an

information expert will be focused on facts, with little regard for views, attitudes and opinions. In my view, there is no room for leaders who lack well developed communication skills in order to network effectively, listen and pay regard to local opinion, and to present a clear vision for improvement supported by evidence and data.

An important role for DsPH is to provide expert advice that will help inform policy locally, as well as influencing policy nationally (and internationally). It is essential that this is delivered in a sensitive and articulate manner, backed by information and data sourced from a range of organisations, and not simply from traditional health sources.

DsPH need to have the courage to strive for better alignment of local and national policies, with clear roles identified and maximised across statutory, private and third sectors. This in turn will impact on the culture and effectiveness of local partnership working at all levels. The Department of Health is attempting to build a sustainable system that includes developing incentives for organisations so they feel able to invest in programmes to reduce health inequalities where the benefit is realised elsewhere, or even many years later. If this is to be successful then local involvement by DsPH,

acting as the 'catalyst' and engaging all relevant partners in potentially difficult negotiations, will be important. Developing performance measures against outcomes that we know will bring health benefit in the future rather than measurable immediate benefit needs, are essential to support joint working and joint investment. The skills highlighted in the 'expert model' will help to identify and implement relevant outcome and process measures.

Critical friend

A DPH must operate in a strategic fashion, understanding that everyone is not necessarily equal when it comes to the impact of their actions. A successful DPH in a joint appointment will work hard to understand who are the true opinion leaders and power brokers on a given topic and within a social system in their local community. In a joint appointment the DPH will work with a variety of local leaders (who may not all necessarily be in formal leadership roles) who are able to lead others and must develop the skills to understand that time and effort spent working with (engaging) them will have a multiplying effect. As highlighted by Elson, from a local council perspective many DsPH do not have the necessary experience of working with elected members, understanding how to engage and lead them through the 'mire'

of difficult and often contentious public health issues, nor may they be appreciative of the difficulties that members may have in managing their locally elected colleagues. This is an important area for further development.

Elson refers to the need to balance the skills of the DPH with the understanding of local council members; for example, where their knowledge, support and understanding are strong then the community leaders/advocate model can be used, or if there is low level of understanding of health improvement, the critical friend model will be more effective. Elson's 'critical friend' model is built on the premise of developing strong relationships where the DPH is seen as credible with their peers and 'followers' across a range of organisations. The introduction of joint appointments, in some areas, has done little to help forge such essential relationships which has meant that personality and skills are necessary for the 'critical friend' model of working to be allowed to develop and flourish.

The local authority described as the best fit for the 'critical friend' model will require investment in the development of the DPH, local council managers and elected members. There is a wide development gap to be filled if DsPH are to be seen as credible by their council peers in

commenting on and contributing to local council policies and plans. Elson's paper suggests that elected members who are close to their local communities become champions and messengers for DsPH. This however will only work if elected members are given the opportunity to develop their own wider political awareness, sensitivity and leadership skills in the context of partnership working.

The adviser

The characteristics described in Elson's paper for the 'adviser model' suggest that joint DsPH use their expert knowledge and skills to advise the council rather than just providing it with relevant information and evidence. This would seem an important part of the role of any DPH and will require courage and skill to lead across organisation boundaries, demonstrating political awareness and skills of persuasion and negotiation.

Many DsPH have little previous experience of working in an influential role in local government. The language, acronyms, performance requirements and organisational culture are very different from those in the health service and there is often inadequate induction for senior individuals entering the organisation. There is generally an expectation that

they will 'pick up' the required knowledge 'on the job'. As highlighted in Elson's paper, many DsPH do not fully understand the roles and responsibilities of their senior peers in local government, nor the career paths they have experienced on their professional journey. Equally, DsPH often express their concern that their peers in local councils do not fully understand the culture of the health organisation that they have agreed to work in partnership with, nor the background and role of the person designated to lead the partnership i.e. the DPH. Clearly more could be done to educate appropriate individuals in both organisations, for example through joint learning forums, briefing papers on organisations, formal organisational inductions, setting up mentoring or 'buddying' processes across organisations.

The local authority best fit described by Elson suggests this model will work well where there already exists an understanding of the health improvement agenda in councils without a highly confrontational political tradition. The tensions described in the paper outline the difficulties and sensitivities that many DsPH will face at some time in their appointment where their skills of political astuteness need to be well developed and any expectation of providing an independent view on health improvement will need to be reconciled with both organisations.

The provider

Characteristics of the DPH role in the 'provider model' suggest the need for strong operational management skills and expertise. Such a role may not be familiar to many DsPH, who would normally be part of a wider team comprising of experts in the areas of finance, planning, performance etc. The role a DPH should play in all councils is to share understanding that performance ratings for individual organisations can only provide part of the picture, with regulators using different methodologies and timeframes for their assessments, it makes comparisons difficult. Obtaining an overall assessment of all organisations working locally to improve health and well-being will be problematic for the DPH because of the differing functions, aims and geographical boundaries of agencies although PCT and local council boundaries are now more closely aligned following PCT reconfiguration.

The Department of Health has stated that it will develop a joint approach to accountability for any future Public Service Agreements in a further effort to signal that health inequalities cannot be improved by silo working (Department of Health 2008). The development of Comprehensive Area Assessment (CAA) is welcomed and should go some way to addressing issues of collaborative working, although it should be recognised

that different regulators will still have different regimes to meet the relevant regulatory legislation. CAA will provide new opportunity for DsPH to develop their accountability in local councils for improved health outcomes through priorities identified in Local Area Agreements (LAAs).

The local authority model of working described as the best fit for the 'provider' role, where senior council managers hold service responsibility, risks distracting DsPH from their core expertise and interest. It is likely that the additional burden of managing large budgets as well as other operational management tasks will be of little interest to many DsPH and would be better undertaken by other team members.

The catalyst

The 'catalyst role' of promoting interagency working through building trust described by Elson is an important one, required across all models of working. It is particularly important during the current period of transition where two organisations with very different cultures and ways of working are expected to collaborate on joint agendas such as Joint Strategic Needs Assessment, agreeing priorities for LAAs etc. An example used by Elson refers to the DPH annual report, which historically has

been highly visible to the local community and across the health system. But if it is to be valued by local council members then shared input and a joint role in its development will be necessary.

The 'catalyst model' highlights operating in at least two distinct cultures as a particular style of working with skills required to lead through engagement, networking and partnerships across organisation boundaries often with little or no formal authority to do so. DsPH and other senior members working in these joint teams need the ability to handle conflict between organisational priorities and loyalties, to be able to understand the 'art of the possible', and to judge when and where to act for maximum influence in the short and long term. In 'silo' networks, individuals will have their own reasons for why they will or will not engage in action and it is essential to attempt to understand these individual rationales. Engaging others in action is the essence of meaningful leadership (Alimo-Metcalfe & Alban Metcalfe 2005).

The community advocate and friend

DsPH in joint appointments are working within a social and political context made up of other leaders and people of power. These political forces operate both locally and nationally. Elson describes such skills in the 'community advocate and leader' model as ones where DsPH will need to develop a keen sense of political awareness, knowing who needs to be involved in decision-making; who needs to be 'kept on board'; when the best time to move on an issue is and when it is best not to fight a particular battle. All DsPH need to be tuned-in to the local (and national) political context, whilst retaining their autonomy to act with personal integrity in whichever type of organisational model they are working in. Political sensitivity is required by all DsPH in the new environment they are now working. Deep understanding of party politics is required in order to survive professionally and contribute effectively to complex debates.

Transition

It is important to explore the possibilities and opportunities of managing the transition for both DsPH and their organisations in a way that maximises the learning and development and minimises the personal and organisational costs of a senior leader's failure to be effective in a new joint appointment.

Bridges (2003) provides a useful framework for understanding the process of transition in which he stresses the importance of understanding the difference between change, which is situational, and transition, which is the state that change puts people in. He describes the psychological process that requires people to go through a three phase process as they internalise, and come to terms with, the details of the new situation that the change brings about. Understanding and working through these stages would be of benefit to DsPH as they (and their teams) develop into their new roles (see box 1).

box 1

Stages of Transition

1

Letting go of the old ways and the old identity people had. This first phase of transition is an ending, and the time when people need help to deal with their losses.

2

Going through an in-between time when the old is gone but the new isn't fully operational. This time is called the 'neutral zone'; it's when critical psychological realignments and re-patterning take place.

3

Coming out of the transition and making a new beginning. This is when people develop the new identity, experience the new energy, and discover the new sense of purpose that makes the change begin to work.

Bridges W (2003) Managing Transitions - Making the Most of Change.

Crucial to exploring the role of DPH joint appointments is an emphasis on how leaders learn and the extent to which they are conscious of both the need to do this and the actual experience of learning. With an open attitude, DsPH can go into their new role in a way that allows them to 'formulate a theory or new assumption as a result of their experience' as opposed to a closed attitude where they are looking 'to fit it into a preconceived theory or set of assumptions'. Clutterbuck and Megginson (2005) state that the 'structure and pace of work allows less and less time to think about what we are doing and why'. The antidote they prescribe is the

'creation of reflective space and the need for the opportunity to halt the frenetic pace of doing and to refocus on being'. Dotlich et al (2004) agree: 'Typically you're so caught up in the excitement of a transition or the complex issues it raises that learning is the last thing on your mind'.

Meeting the development needs of joint directors of public health

Elson's models are intended as a way of thinking about what proportion of time joint DsPH spend on working in a particular area depending on local circumstances. However, the notion of continuous improvement requires organisations to be flexible and adaptable, always testing out new ideas and being prepared to make improvements. This would require the DPH to have well developed transformational leadership skills as well as the skills and courage to bring challenge (as in the 'critical friend' model) as a change agent. The 'fit' suggested between the skills and characteristics of a DPH and the culture of the local council needs to allow for this flexibility or it will bring a risk of too close a match, and therefore no challenge or change being introduced.

There appear to have been few attempts (nationally by government departments, or more locally at a regional, local council or PCT level) to support DsPH to develop the leadership knowledge, skills and behaviours required to effectively fulfil their challenging new roles. A notable exception is the Leadership for Health Improvement Programme (LHIP), commissioned by the Department of Health and piloted

across Yorkshire and the Humber and the North East during 2006/07, it began the process of developing a multiagency cohort of senior people who excelled in the knowledge and skill domains of leadership, improvement methodologies and health improvement systems (Hannaway, Plsek & Hunter 2007).

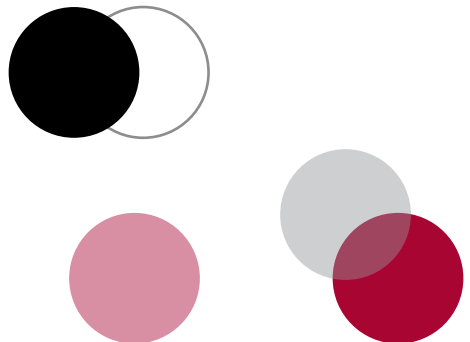
By emphasising mental processes such as challenging, flexible thinking and purposeful rethinking, DsPH can be encouraged constructively to destabilise the health improvement system they are central to improving. Evidence of supporting 'whole-system' improvement efforts undertaken by the Improvement Foundation across primary care suggests that it is a whole system approach to building partnerships, developing shared governance, building relationships and introducing innovative ways of working that is responsible for success such as the decline in waiting times for GP appointments, the introduction of radical approaches to the provision of services in primary care etc.

One approach to managing the transition for joint DsPH appointments might be an expectation that they should put together their own support and development arrangements and secure commitment to them. Tony Elson's paper is helpful in highlighting the possible scenarios they may be working in from a local council perspective, which could then be mapped by individuals against the Public Health Career Framework to identify skill gaps. This approach would be consistent with the sense of personal responsibility that underpins the philosophy of 'Self Organised Learning' (Harri-Augstein and Webb 1995) but it also requires recognition that it will be more effective if this personal responsibility is part of an organisational commitment to learning as critical to personal development, organisational development and improved performance (Senge 1994).



Conclusion

Key priorities for local government and the NHS, such as 'place shaping' and 'world-class commissioning', demonstrate the need for strong, visionary, transformational leadership. Whilst the focus of this paper is on how local councils can get the most from a jointly appointed DPH, paying attention to the personal and organisational development of fully integrated multiagency teams with a receptive culture for change, pooled budgets and shared governance arrangements lies at the heart of real progress.



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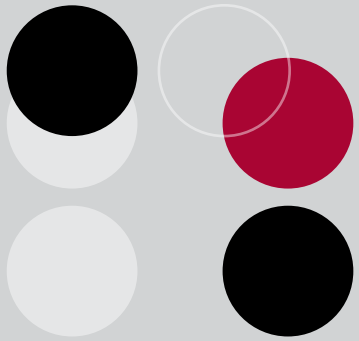
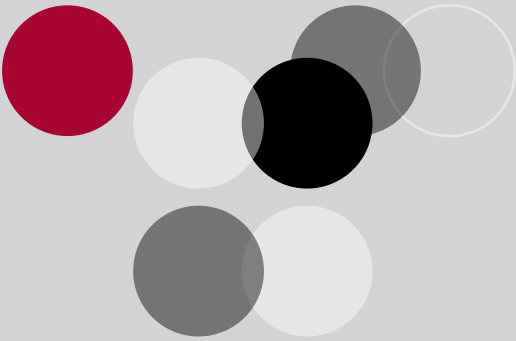
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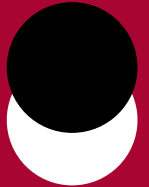
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