

**ENABLING THE DEVELOPMENT OF
PUBLIC HEALTH NETWORKS**

**NATIONAL PUBLIC HEALTH NETWORK
ACTION LEARNING SET PROGRAMME**

**SUMMARY REPORT
MARCH 2004**

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**Public Health Network
National Action Learning Sets for
Network Managers and Leads
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1. Introduction and Background

In the past few years numerous policy documents (The NHS Plan¹; Saving Lives: Our Healthier Nation²; Shifting the Balance of Power³) have outlined the key public health roles and responsibilities of primary care trusts (PCTs), strategic health authorities and public health professionals in England. PCTs in particular are to be the 'engine of front line delivery' (FPH⁴). However, for many of the more specialist public health functions, it is unrealistic for every PCT to have its own expert, and in many cases public health expertise is distributed across several levels of the health system. 'Shifting the Balance of Power'³ in particular provided national guidance for setting up public health networks. The purpose of these networks is to:

- "Provide coordination of the specialist public health function thereby making best use of scarce skills and resources across the whole of the public health workforce;
- Prevent professional isolation and provide professional accountability
- Plan public health interventions, especially those dealing with health inequalities at a local level." (FPHM⁵)

Public health networks are at a formative stage, though across England there is great variation in the level of network maturity as organisations in their own right. A series of regional workshops, funded by the Department of Health, on developing public health networks took place between November 2002 and February 2003 culminating in a national workshop in March 2003. The national workshop identified a number of areas that needed developing by network managers or leads. These included:

- Clarity in the processes for individuals leading on a piece of work for a network;
- Developing common standards for shared pieces of work;
- Network governance arrangements and communications
- Developing ways to identify 'best practice' and how to share these
- Identifying data requirements and gaps in accessing data
- Developing mechanisms for encouraging evidence based practice within networks
- Identifying ways of managing relationships across different public health networks.

In order to facilitate more coherent development in these areas the Department of Health commissioned the Public Health Resource Unit in Oxford to run action learning sets for people involved in managing public health networks. Four learning sets were established targeting network managers and leads from across the country, grouping them into regional groups. The regional groupings were as follows:

- London and Eastern Regions – meeting in London
- North East, Yorkshire and Humber, East Midlands – meeting in Leeds
- North West and West Midlands – meeting in Crewe
- South West and South East – meeting in Reading

The aim and objectives of this public health network lead development project were:

Aim: To enable public health network managers and leads to develop effective public health networks through problem solving, shared learning, leadership and skills development.

Objectives:

- 1) The programme will build on participants' existing skills, experience and expertise, enabling them to:
 - a) Improve their capacity and capability to problem solve and manage their network;
 - b) Improve their capacity to share and good practice;
 - c) Enhance networking with other network managers and to promote ongoing links and networks beyond the life of this learning set
- 2) The programme will spread learning on effective network management by:
 - a) Documenting and making accessible key areas of good practice
 - b) Ensuring wide coverage of documented materials within a range of key organisations.

Before the learning sets began most of the prospective participants who had signed up were interviewed on the telephone by the facilitation team. The purpose of the telephone interviews was to find out both what the network issues were that participants were facing and to gather some information on what participants hoped to achieve in the learning sets. This helped with preparing the first two-day session.

At the first meeting of each learning set the facilitators guided participants in discussions about their own understanding of what a public health network is, and to develop their own objectives for their learning sets. The next session describes these in more detail. Each set met four times, with each session lasting two days.

2. Objectives and working themes for each learning set

Table 1 outlines the objectives that were developed by participants in each learning set.

In general there was a reasonable shared understanding of what a public health network was. Participants' discussion on "what a public health network is" centred primarily on function, structure and operation. The Leeds and Crewe learning set participants were particularly exercised about whether networks were always an appropriate response to public health capacity needs and therefore focused on functions of public health networks, – 'form follows function'. This appeared to be less of an issue for the London and Reading learning set participants.

Table 1: Learning Set objectives as defined by learning set participants

London	Leeds	Crewe	Reading
Improve influencing of chief executives and supporting DsPH	Specify public health network function, effectiveness and added value	Understand and agree core functions of a public health network	Acquire networking skills in influencing/negotiation; managing change and leadership.
Define structure of managed networks, boundaries and options for flexibility	Identify potential capacity and resources for networks	Develop criteria for establishing and/or engaging in networks	Improve information and knowledge management
Define accountability of networks	Consider linkages with other organisations and networks and how to create synergy	Establish mechanisms for getting commitment and ownership from others	Improve marketing/public relationship skills for influencing others
Analyse how to evaluate networks	Improve ability to build commitment and engagement to networks	Develop mechanisms for making networks dynamic	Increase understanding of corporate culture and workforce development issues;
Consider relationships between networks and other public health bodies (health protection etc.)	Define and explore governance and accountability issues	Develop ways of measuring the effectiveness of networks and assessing added value/standards	Develop wider contacts and create greater resources to help public health networks operate.
Improve understanding regarding public health information resources			
Identify priorities for the network			
Address problems of credibility of network managers			

As can be seen from the Table 1, some key themes were developed across all four learning sets. These were:

- 1) Better understanding of what public health networks can do – what are their functions?
- 2) Better understanding of models and structures of networks – what do they look like?
- 3) Better understanding of the political and organisational dynamics that networks need to work with and influence.
- 4) Skills development for network leads and managers in change management, influencing and communications/marketing.
- 5) Better understanding of other public health players and how networks relate to these – Health Protection Agency, Health Development Agency and Public Health Observatories.
- 6) Evaluating effectiveness and value-added of networks

3. Results of work on themes from across the learning sets

Each of these themes will be considered in turn for key learning points, debates and conclusions (if any) reached by the different learning sets.

1) What are the functions of public health networks?

This question was considered primarily by the Crewe and Leeds learning sets, though similar issues arose in discussions between participants in London and Reading. As the discussion evolved participants were able to clarify that they were talking about what public health functions or deliverables were expected from PCTs. Once these were defined they were able to then consider at what level these functions were delivered. Five main public health functional areas that are the responsibility of PCTs were identified and are shown in Table 2.

Table 2: PCT Public health functional areas for coverage by networks

Category	Specific functions
<i>Public health workforce development</i>	<ul style="list-style-type: none"> • Continuing professional development • Workforce planning • Peer appraisal and review • Professional peer support • Surge capacity planning • Audit and maintaining standards • Capacity development • Teaching and training
<i>Public health knowledge management</i>	<ul style="list-style-type: none"> • Public health intelligence • Public health information analysis • Sharing and building good practice/expertise • Networking with other agencies and internally • Developing and advising on evidence – using research and academic links
<i>PCT health protection</i>	<ul style="list-style-type: none"> • Emergency planning • Screening • on-call arrangements • Vaccination and immunisation • Resilience planning • Chemical incidents, pollution control, statutory consultation and decontamination
<i>Delivery of Local Delivery Plans and Public Health Programmes</i>	<ul style="list-style-type: none"> • Meeting inequality targets and working on wider determinants • Engaging with LSPs, local authorities and other partners • Public health advocacy and visibility via the media • Taking the lead for specific public health areas – e.g. NSFs • Providing specialist public health expertise – e.g. dental public health
<i>Input into health service planning provision and evaluation</i>	<ul style="list-style-type: none"> • Specialist commissioning • Public health input into all commissioning and prioritisation

In the accompanying discussion learning set participants worked on mapping out where each of these functions is taking place in their areas at the moment (individual PCT? Cross PCT network? Strategic Health Authority? Regional office? Etc) through creating a matrix. The matrix varied according to both the type of network people were working in and the maturity of the networks as organisations.

2) *What are the models and structures of public health networks in place now?*

Participants described a number of different models of how networks had been set up over the course of the learning sets. The structures varied from being highly organised and well resourced to those networks that were still informal and very loosely organised. At the more organised and structured end of the spectrum of structures, the managed public health network incorporated a 'public health resource unit' with staff who could provide operational public health functions (e.g. health information analysis, health promotion etc.) for several PCTs as well as a regular DsPH meeting. These networks employ full time co-ordinators and other full-time staff as well. At the more informal end of the spectrum the public health network was

comprised of just DsPH meeting on a regular basis to share information, with no dedicated staff (such as a full or part time network lead) or financial resources.

3) *Better understanding of the political and organisational dynamics that networks need to work with and influence.*

Most of the learning sets also undertook a stakeholder analysis to provide participants with a clearer idea of who was key to ensuring the future of networks and their areas of action. The most important players were considered to be PCT Chief Executives, as well as Directors of Public Health at PCT, SHA and Regional Office level. A number of invited speakers representing these stakeholders provided insight into the priorities and thinking of key stakeholders for public health networks. The main messages they had for public health networks were:

- Networks should start with where energy exists. In many places this is around supporting professional and collegial support for public health colleagues, many of whom are in new roles within PCTs;
- Networks must demonstrate impact – one PCT CEO said that if he didn't see visible outcomes of public health networks in the next 12 months he would stop putting PCT funding into the network;
- Networks need to be working on areas that are PCT priorities – keeping in mind what gives or takes away stars can help network leads know what the PCT priorities are. Fortunately with new inequalities targets public health has more of a chance of getting the attention of chief executives and boards.
- Public health in general, whether through networks, or otherwise, needs to raise its profile much higher. A revealing presentation by a civil servant working in the communications office in the DH indicated that amongst the 200+stakeholders considered important to the DH, public health organisations do not figure at all.
- The delivery of public health and how this is managed is likely to undergo further restructuring. Current public health networks will be vital for helping to make the next transition to a new structure.

4) *Skills development for network leads and managers in change management, influencing and communications/marketing.*

Network leads and coordinators recognised that their role is not so much about managing as it is about influencing, brokering and cajoling in order to persuade otherwise busy people to give some time for operational public health work. Many of the learning sets put time into looking at change management and influencing theory, as well as to explore how individuals are working in practice. For many participants, discussions emanating from their dilemma inquiries helped them to unblock perceived obstacles in getting people to give more time to public health work. There was also a much greater understanding of why Directors in Public Health, amongst others, were not able or willing to give their allotted time to the work of networks, or why PCT CEOs were not enthusiastically embracing public health in some areas. This in turn helped people to consider alternative strategies for communicating what networks could do for PCTs and who to get involved.

- 5) *Better understanding of other public health players and how networks relate to these – Health Protection Agency, Health Development Agency and Public Health Observatories, Commission for Health Improvement.*

Learning sets approached learning from other key public health players differently. In all cases, Directors of Public Health Observatories (PHO) were invited to the first sessions of all learning sets to explain their work and to explore how observatories and networks could work together. Table 3 shows the areas of interaction discussed by the different learning sets in their meetings with PHO directors.

Table 3: What Networks and Observatories can do for each other

Observatories for Networks	Networks for Observatories
<ul style="list-style-type: none"> ➤ Data management: provide access to data and data analysis facilities for network members – one recommendation was that PHOs develop a sophisticated search tool that allows a user to see what has been information has already been pulled together across PHOs on specific topics; ➤ Besides being a source of primary data PHOs could also point to, and provide an overview of, other sources of evidence; ➤ Education and training for network members – for example, through secondments; ➤ Disseminate local products from networks, as well as PHOs' own work; ➤ PHOs can help identify gaps and provide information analysis for monitoring health protection issues; 	<ul style="list-style-type: none"> ➤ Networks can act as a conduit upwards of local intelligence, information and resources; ➤ Identify priorities for collaboration and public health needs of PCTs to be delivered by PHOs; ➤ Networks can disseminate work done by PHOs through their membership; ➤ Networks should be represented on each PHO steering group

In general, members of some learning sets felt that PHOs need to be more accountable to the priority work of PCTs and networks – often they are seen as pursuing their own agendas without reference to local public health needs.

Other public health organisations, such as the Health Protection Agency and the Health Development Agency, were either represented through membership of the learning sets, or came as speakers to learning sets. Staff from the HPA who attended the learning sets expressed their concern that the HPA found it very difficult to engage with public health networks in general, especially where the network model was to have no central point of contact. There also appeared to be a degree of confusion as to how HPA staff worked to PCT health protection needs, particularly around issues such as the on-call rota.

There appears to be no formal interaction between staff of the Health Development Agency and public health networks.

There is also an urgent need to engage with the Commission for Health Improvement who is developing a set of standards for public health. There is a potential that the contribution of networks to the delivery of public health standards by PCTs will not be identified and recognised.

6. Evaluating effectiveness and value-added of networks

From the outset many learning set participants expressed concerns with how they would demonstrate that their network was effective. The importance of this became clear to others as both RDsPH and PCT Chief Executives who had been invited to speak to the learning sets hammered home the message that networks will have to show how they are adding value in order to secure ongoing funding from PCTs and elsewhere. There was general agreement, including from RDsPH, that the concept of a one-off 'signing off' networks was probably inappropriate, especially as each network was developing in response to local need. A model for 'stages of maturity' on public health networks had been developed, using six categories, each with four stages:

- Membership
- Accountability
- Resource co-ordination and administration mechanisms
- Organisational structure
- Communication
- Risk management and arbitration
- Relationships with other statutory and voluntary organisations and clinical networks

(From: North West Regional Office, Public Health Office)

All of the learning sets also looked at the HDA tool for assessing partnerships to see whether this could be adapted to evaluate how networks operate. There was a mixed reaction to the tool from different learning sets, with some feeling it was highly appropriate and others feeling it was very inappropriate. As both the 'stages of maturity' model and the HDA tool only assess how networks or partnerships function in themselves they don't answer the question of what impact the network is having on delivering public health.

Work done by the Crewe and Leeds learning sets on evaluating effectiveness and value-added led participants to conclude the following:

- Need to be clear about what public health problem is being resolved – is the problem analysis 'right'? Do we know what we don't know?
- Need to have clear objectives about what the network is delivering and communicate these to key stakeholders;
- Need to 'brand' what is delivered by networks so that the work is visibly identifiable as the product of a network (some networks already have logos that they use for reports and letters);

4. Summary comments from learning set evaluations

At the last session of each of the learning sets, participants were asked to fill in a longer form than usual to provide written feedback on the learning sets. They were asked to comment on *their outcomes* from the learning set: e.g. what their three key learning points were; how well developed their understanding of networks had become and to comment on their 'action plan' for after the learning set. They were also asked to comment on *the learning set process*: e.g. how well they felt the learning set had functioned, how well they had participated and how well they felt the learning sets had been facilitated. These comments are being fed into the external evaluation currently being carried out by Oxford University.

In general, the written feedback at the conclusion of the learning sets was very positive. Participants felt they had greater clarity both about what public health networks can do, and what their own roles within networks were.

"I can be pro-active in taking things forward with the xxx network as my role is quite

flexible and my job description suitably vague”.

“The learning sets have given me the opportunity to share my dilemmas and local issues and clarify my role within the network.”

“I don’t need to take total responsibility for running the network – I must share this with others”.

On the learning set process, participants were also very positive. In response to the statement “The one thing that stands out for me in terms of our set is:” participants said the following:

“The support and discussion amongst the set – I particularly enjoyed the dilemma sessions and how the group worked to tease out solutions/issues.”

“The challenges and new ideas which have been presented to me – my thinking about PH networks has developed and changed as a result of this learning set”.

5. Concluding thoughts

Discussions in each of the learning sets were rich and varied. The results pulled together for the previous session only gives a taste of the wealth of experience and thought provided by participants. It is evident that participants deeply appreciated the inquiry sessions and enjoyed the chance to hear other’s views on networks.

Many participants in the learning sets have created mechanisms for meeting on an ongoing basis where it makes sense for them to do so. These meetings are to look at ways for working across networks, as well as to provide support and help for network managers and leads. Participants also shared documents and materials they’ve developed for their own networks to be shared across all public health networks. These are listed and categorised in Appendix 1. An external evaluation of the learning sets is currently being carried out and will be reported on separately.

As the learning sets were finishing up, a number of concerns and issues remained unresolved. These are highlighted here for further work to be done:

A question

- *Form following function?* In some regions there is a poor understanding of what public health networks have been created for, other than the broad outlines provided in policy documents. In these cases, where form has preceded function, there appears to be little engagement with or commitment to making networks succeed and PCTs have created alternative routes for delivering their public health priorities;

Broad issues

- *Public health specialist capacity and responses:* There are critical capacity problems in the parts of the public health workforce. Public health networks were conceived to help respond to some of these problems. However, some PCT Directors of Public Health often find it difficult to contribute to public health networks in their areas due to time constraints, despite having a network role written in their job descriptions. Also, in some areas, public health networks were resourced early on essentially to recreate public health specialist teams (known in some areas as ‘public health resource units’) to provide PCTs with support for their public health work, but this remains the exception. Public health workforce capacity remains an issue of primary concern across England.

More specific concerns

- *Poor integration of other public health professionals:* In many areas other professionals involved in delivering public health are not considered to be part of public health networks, and are therefore not included in the planning or delivery of public health, as agreed by network members. This is especially true of health promotion specialists and community nurse teams who in some places have created their own networks for professional support.
- *Creation of public health “silos”:* Exacerbating the problem of integrating certain teams working within PCTs is the setting up of quasi-governmental public health organisations, such as the Health Protection Agency and Health Development Agency, as well as the separate Public Health Observatories. Learning set participants and speakers from these groups pointed to problems they were confronting with having influence over PCT public health priorities, and vice versa. Networks could potentially provide a space for pulling together these disparate groups, but are currently not mandated, resourced nor organised to do so.

Those working in public health networks are faced with several challenges in meeting public health priorities of PCTs because of these organisational issues. The thinking and discussions in the learning sets have helped to highlight the challenges, clarified people’s thinking about why they are having problems and provided some pointers for ways to take public health forward locally through networks.

The learning sets were particularly helpful in clarifying people’s own thinking about what their network could and should be doing. Participants found that developing a matrix that allowed them to map where PCT public health functions were being delivered in their health economy particularly useful for defining what their network should be supporting. Through this and other discussions the sets helped participants to see where the network model could be a real opportunity for helping to raise the profile of the public health, meeting population health needs and reducing health inequalities.

APPENDIX 1
Network Documents available for sharing

Category	Documents available	Where from
<i>Governance and accountability documents</i>	<p>Network terms of reference</p> <p>Governance and Accountability Framework</p> <p>Steering group - terms of reference</p> <p>Network business plan</p> <p>Network coordinator job description</p> <p>Service level agreements</p>	<p>Lincolnshire, Northants and Rutland</p> <p>County Durham and Tees Valley</p> <p>Cumbria and Lancashire ERPHO</p> <p>County Durham and Tees Valley South Staffordshire Cheshire and Merseyside SE London, ERPHO, Essex. Surrey and Sussex.</p> <p>Lincolnshire, Northants and Rutland County Durham and Tees Valley SW London, Cambridgeshire and Peterborough, ERPHO</p> <p>County Durham and Tees Valley South Staffordshire</p>
<i>Programme delivery</i>	<p>Functional matrix</p> <p>Service specification for HIA support</p> <p>Framework for joint commissioning of sexual health and teenage pregnancy</p> <p>Model of consolidated health promotion services</p> <p>Network work plans</p>	<p>County Durham and Tees Valley</p> <p>South Yorkshire</p> <p>Warwickshire</p> <p>North and South Staffordshire</p> <p>SW London, Norfolk,</p>
<i>Workforce capacity</i>	<p>Public health capacity building programme</p> <p>Business case for WDC investment in PH specialist training</p> <p>Info on CPD days and how audit occurs</p> <p>CPD/Education and training policy</p>	<p>County Durham and Tees Valley</p> <p>South Yorkshire</p> <p>North and South Staffordshire SE and SW London</p> <p>North London South East Region</p>
<i>PH Intelligence Analysis</i>	<p>PH Intelligence Service publication "Miserable measures" – PCTs by deprivation index</p>	<p>County Durham and Tees Valley</p>
<i>Health protection</i>	<p>Emergency planning database</p> <p>Network protocols for screening</p>	<p>South Staffordshire</p> <p>South Staffordshire</p>
<i>Risk Management</i>	<p>Risk assessment</p> <p>Corporate governance and risk strategy</p>	<p>North London</p> <p>Cambridgeshire and Peterborough</p>
<i>Communications</i>	<p>Communications strategy</p> <p>Specification for website</p>	<p>ERPHO</p> <p>SE London</p>
<i>Specialist input</i>	<p>PH support to specialist commissioning</p>	<p>South Yorkshire</p>

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