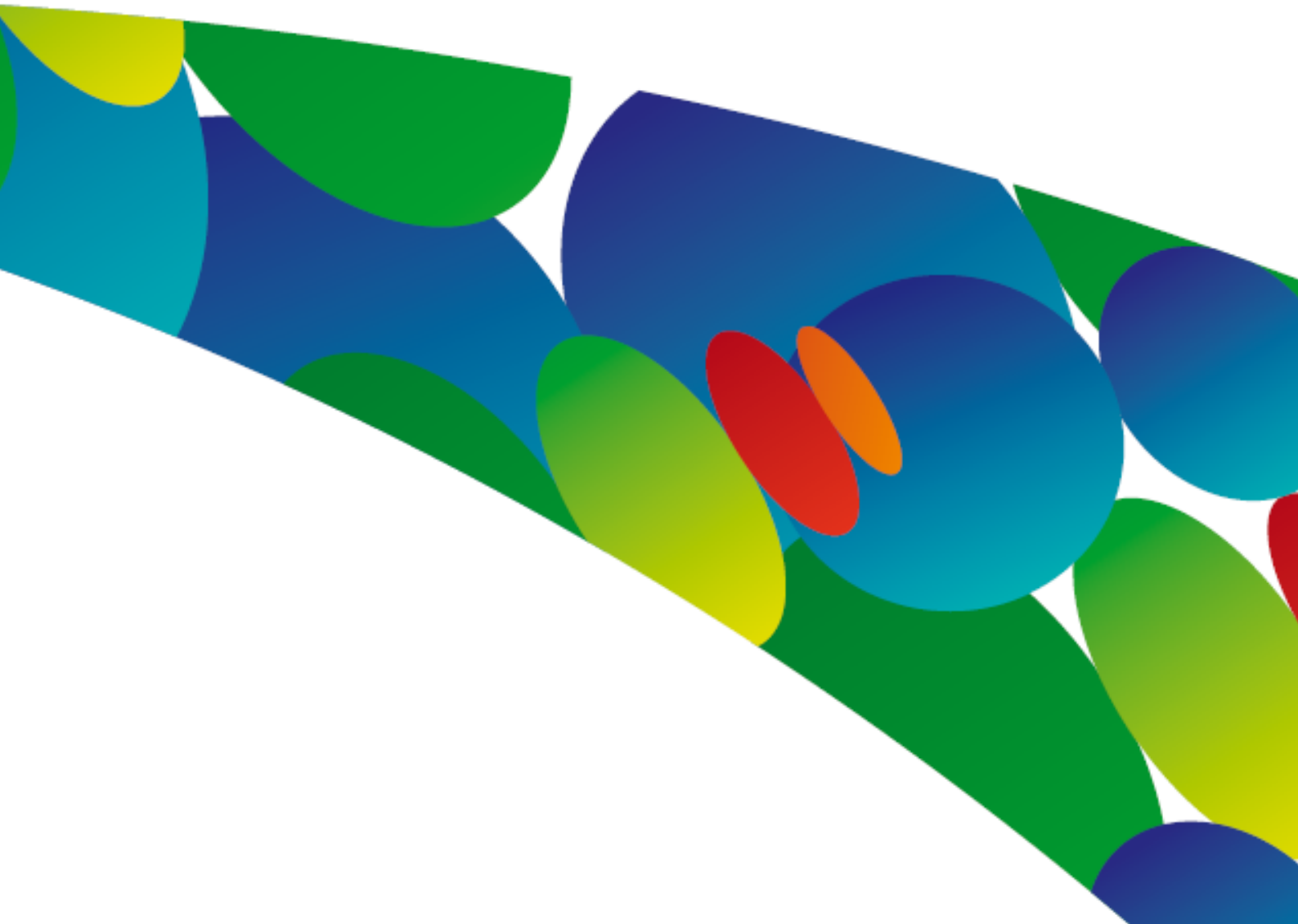
The Public Health National Support Teams 2006 - 11



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Description	This workbook was developed by the Support Teams (NSTs) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions. This is offered as useful resource for commissioners: use is NOT mandatory.
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Contents

1. Introduction

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People's Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships (Appendix 1) during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed. This document offers a summary overview of the history of the National Support Teams, how and why they were established, the NST approach, the lessons learned, and the value of such support.

These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

2. Brief History

The original impetus derived from the desire of DH to see practical delivery of public health interventions improving more rapidly at a time when much of the frontline was evidently struggling with organisational reform. The initial project team (formed much as the private sector often handles start-up, or the voluntary sector manages new service development); comprised a small team of people used to working across the different cultures of the civil service, NHS and local authorities and was led by Cathy Hamlyn, a former Health Authority Chief Executive. Under her visionary leadership, the team created and tested a different type of intervention designed to quickly achieve genuine improvements in local public health interventions and outcomes.

Starting with two complex topics, sexual health and tobacco control, the results from these field teams were sufficiently encouraging that further work was commissioned to develop specialist teams providing support in relation to a further 8 topics as listed in the introduction above. By their close, early in 2011, NSTs were highly integrated into central thinking, a source of stability for local clients, the most visible concentration of national-level behaviour change expertise, and in a position to present a persuasive case as regards value for money.

3. Purpose and Approach

The NSTs were specifically developed to provide informed support and expertise, (as distinct from inspection or audit); as one Local Authority Chief Executive put it, "People thought it was going to be like an inspection but it didn't feel like that – the NST facilitated us, walked alongside us and were very helpful."

The stages of the approach fitted very closely with Peter Block's well-regarded prescription for 'flawless consulting'[1], and a consultancy approach which many partners and clients of the NSTs recognised was in use themselves; Appreciative Inquiry. This started from work in hospitals[2], where it was recognised that there was a shared motivation amongst clinicians and managers to identify what worked well and build upon it. An attractive element, both for practitioners and clients, was the emphasis upon the positive potential to achieve, rather than always seeking a 'problem' to 'fix'. The working model of Appreciative Inquiry adopted by the NSTs looked carefully at the whole system, not just the individual designated 'problem owner'. This approach enabled NSTs to look beyond the original perceived problem to bring back genuinely fresh insights to the clients.

4. Expertise

The NSTs were successful in recruiting many of the leading lights of the small but closely inter-connected public health fields they served. Those recruited as senior managers were responsible for initial client contact, higher-profile presentation work and running the diagnostic process. Associate managers were also experts in their fields, taking an active part in the diagnostic process and then responsible for handling the post-visit follow-up support. For the key diagnostic staff, the professions included medicine, psychology, nursing, social work, teaching, public health management, local authority management, and law. By the final two years of the NST programme, everyone professionally involved in public health in England during the period 2006-2011 could recognise and respect names on the staff list. Use was also made of occasional expert contractors, recruited from a wider set of professional backgrounds.

5. Site Selection

Each NST had a site selection procedure agreed with its key funders. Some localities nevertheless invited NSTs pro-actively, often through raising the awareness of national policy leads as to the perceived need for support on particular public health work-streams. In these cases, the main issue in pre-visit planning was often the need to ensure sufficient director-level availability and input for the diagnostic element. In some other localities there was a clear case for providing an input, but the clients required further persuasion before they were willing to engage fully; in a small minority of such situations, diagnostic visits were postponed until such engagement had been negotiated.

6. The Diagnostic Process

The diagnostic events were introduced through an opening 'plenary' with presentations from the NST describing the process, and from senior people in the area visited who gave an overview of the health profile of the population and of the current status of the subject of the visit. This was backed-up by desk-top analysis of various data. Interviews with individual key stakeholders followed and served a crucial role when used selectively for securing frank input, particularly from senior leaders. Group sessions were also found to make a very effective complement to individual interviews if run as an integral part of the process. The diagnostic process itself often proved to be an effective means of engaging local thinking upon the thematic focus of the visiting team (e.g. teenage pregnancy, alcohol harm reduction, etc.); as Appreciative Inquiry posits, "positive questions lead to positive change"[3].

7. Arriving at and Presenting Findings

NSTs developed detailed procedures for triangulating the results of individual and group sessions, together with the analysis of the expert teams in the field, to present new ways forward for clients. Producing a memorable and engaging narrative for clients started at the writing stage, with the identified presenter receiving input from the rest of the team as to how to present the material. In the NST feedback reports, usually delivered as PowerPoint slides, recognition of local strengths and the scale of the challenges faced was followed by clear, practical recommendations and one-page action summaries that were widely used by executive boards.

8. Follow-up

Following visits, NSTs handed responsibility back to clients to lead change. Recommendations typically included appropriate 'quick wins' to build confidence in change; for instance, one locality that had spent around £100,000 on an advertising campaign incorrectly badged as social marketing was advised to cut this and were able to both save money and focus on better service design and commissioning immediately. NST follow-up support combined elements of both technical and strategic consultancy input. However, the high frequency with which actual support activity was delivered in the form of facilitated 'visioning days' is testament to the reality that addressing gaps between aspirations and current organisational behaviour was often of more pivotal importance than the simple application of technical knowledge.

9. Practical Responses to Resistance to Change

Flexible thinking was often central to getting NST recommendations understood and used. The reasons for resistance were not always obvious but included discord about responsibility for action, shock at how bad things had revealed themselves to be, genuine concerns about the resources or mandate required to make the change happen, and competing interests – whether overt or hidden. Some localities required visits by more than one NST before overarching messages about leadership, partnership working and commissioning were taken on board. The joined-up nature of the feedback they received allowed for a sustained response to work past initial resistance to change.

NSTs developed methods to work with such objections in line with Gleicher's formula[4], D x V x F > R: (Change will occur when the product of dissatisfaction (D) with the present situation, a vision (V) of what is possible, and first steps (F) toward reaching the vision are greater than the resistance to change (R). If any of these (D, V or F) is zero or near zero,

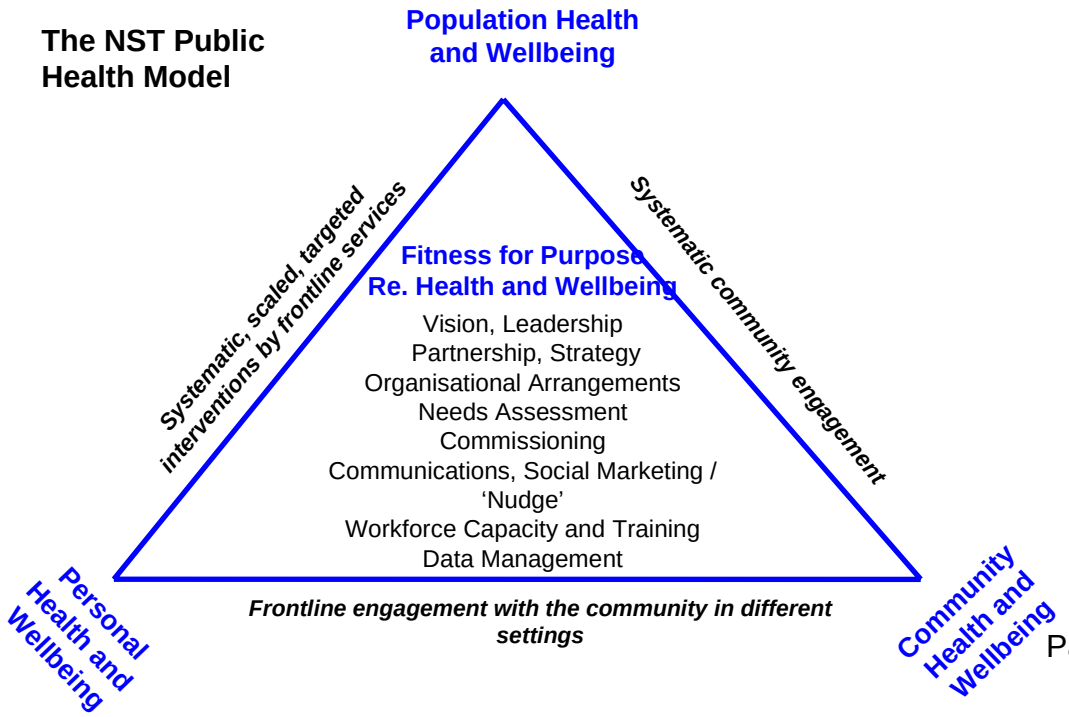
the product of the three will also be zero or near zero, and therefore the resistance to change will not be overcome... a critical mass of the organisation needs to share a common understanding and agreement on each of these three elements for change to occur).

Dissatisfaction on the part of NHS leaders or Department of Health policy leads was indeed the initial stimulus for the support visit in some cases, but if this was vocalised as the starting point for discussion it essentially invited a feeling of being judged or 'inspected'. Part of the response was therefore to ensure that visiting NSTs identified and recognisably summarised local dissatisfaction with the status quo. Accessing this dissatisfaction and getting it usefully into the open required two skill sets; those of asking the right type and mix of questions to establish trust and get to the heart of the issues, and then of presenting the resulting insights in a compelling and engaging manner.

NSTs were also able to assist in a more public fashion by supporting the formation of a unifying vision that encompassed and, to the degree possible within inherently competitive contexts, united personal and professional interests behind a shared goal. This involved showing in detail how the board-level vision of where the organisation(s) should go, the specialist / technical vision of what services they needed to get there, and the opportunities for process re-engineering, came together. Because the NST feedback came with official backing as well as the opportunity to examine resources in detail, it often overcame the resistance that sprang from accountability-uncertainty ('is this really my problem?') as well as practical finance and power concerns.

10. Applying the Methodology to Public Health

As one NHS chief executive put it: "We view the NSTs as an expert public health resource which we have drawn heavily on, helping us to see what is going well, what not so well and what we can do better"[5]. NSTs were created and developed specifically in response to public health challenges, and one of their most popular models was the 'triangle' of public health behaviour change. The triangle often served as a positive early reminder that public health problems, which include vital elements of behaviour change, are only fully susceptible to an approach that combines individual and community-level services with national co-ordination and/or marketing.



Providing access to leading experts frequently resulted in greater local awareness of recognised best practice and the latest peer-reviewed research. Even more often, NSTs were able to assist by filtering available documentation, and directing attention to material able to shed the most light (which in many cases included Government publications). This was complemented, where necessary, by NST-produced documents such as the 'high-impact changes' summaries for sexual health and tobacco control which received considerable praise from local strategists as a comprehensive starting point to implementing Government policy.

11. Learning and Emerging Themes

A systematic analysis of main themes arising from NST reports[6] identified a number of recurrent issues that each of the teams found to be keys to the change necessary for improved outcomes. These were vision, local leadership, organisational and partnership arrangements, data, commissioning and performance.

Vision

NSTs often found themselves making recommendations for change on two levels:

- Strategic vision – for where the organisation, or the local partnership(s) are heading and what they wanted to achieve overall
- Thematic/operational vision – what can be achieved on this topic (e.g. teenage pregnancy), or by this service, in a set timescale

These two broad areas of vision could overlap, but the key for clarity and impact was that they should not be in conflict; if, for example, an NST simplistically recommended that its own particular specialism should become the area's top priority when NHS and local authority leaders had already agreed other themes or issues (like changing boundaries or settling budgets) as the most pressing local driver, salience and impact would have been greatly reduced.

NST recommendations around vision therefore tended to take one of two main directions; either they were about winning more realisable support for the particular theme or specialisms, or they pointed to how that public health theme could support progress on the wider organisational challenges – for example as a foil for renewed partnership effort. In many cases, of course, the presentation of findings illustrated the potential to do *both*, and NSTs certainly offered support to do both, often in the form of 'visioning days' or focused workshop-style events.

Local Leadership

The issue of local leadership, as distinct from national, arose in practice as a result of checking for local ability and potential to positively steer action – moving on from nominal champions to named and active leaders. Where this leadership was lacking, NSTs typically recommended one or more of the three approaches below:

1. Improve the effectiveness of leadership through professional development
2. Work diplomatically to get the subject allocated to a higher-level leader (whether elected or professional)

3. Raise the profile of the public health issue concerned in order to enhance the engagement of influential leaders with the subject

Organisational and Partnership Arrangements

The degree to which organisations and the partnerships that they were members of aligned and co-ordinated their efforts to a specific end, were the frequent focus of NST attention. Often the challenge identified was one of establishing not just formal partnerships but a partnership process that mirrored and enabled strategic delivery, developing a clear and shared vision at strategic level, deploying this at commissioning level, and finessing the system to maximise effectiveness at operational level. Identification of opportunities to strengthen partnership working at a number of levels, and recommendations to achieve this, were thus common. Assistance to move this along was often offered in the form of the 'visioning days' mentioned above, which gave scope to look beyond what individual groupings were doing to how they functioned as a system, and the way they set, managed, and communicated their agenda both internally and externally.

Data

In a retrospective analysis of common themes from NST visits[7], the second most frequently explored was data – or rather information. Typically, the opportunity that the NST identified was around making fuller and more effective use of the data already available. A simple example would be a recommendation to undertake specific, additional pieces of data analysis to inform their approach to the particular topic area. A similarly straightforward recommendation that occurred regularly was to amalgamate data management into a single stream or database, often required to tackle duplication or repeated-entry issues in a locality that had merged from several smaller areas. Frequently, the opportunity as yet under-utilised was about combining the quantitative epidemiological data (within products such as the Joint Strategic Needs Assessment (JSNA)) with the qualitative intelligence from a range of client/patient engagement activities. This in turn often showed promise as a means of informing improved planning processes and commissioning decisions – another high priority recommendation in many NST reports.

Planning

Recommendations about systems-wide planning were generated by the majority of NST reports. One of the most frequent suggestions was that localities stood to benefit from building upon the existing relationships involved in strategic overview to practical action planning in specific public health arenas. This could include taking into account new national guidance or other local or national developments, developing a plan from scratch, or ensuring a plan had actual actions or deadlines set and publicised.

Commissioning

One of the most high-profile themes in the public health arena in general in the period that the NSTs were active was that of commissioning – ideally, the move from transactional purchasing to becoming a fully informed 'smart customer'. Some example recommendations are given below:

> (There is a need to) "…Designate a lead commissioner for sexual health services, with formal delegated responsibility for the budget, to clarify commissioning arrangements and ... to inform intentions and plans for future service developments." Sexual Health NST

> "We recommend a systematic approach to commissioning emotional wellbeing and mental health. Commissioning decisions need to be informed by... the views of users, parents and other stakeholders and evaluation of the impact of current investments on outcomes." Children's Emotional Wellbeing and Mental Health NST

Performance

The National Support Teams were not performance management interventions. However, achieving and maintaining an acceptable level of performance was often a driving priority for the localities that the NSTs supported. In many cases the obstacle identified was 'scattergun' activity arising from inconclusive reorganisation or undirected interest-led projects, and recommendations were consequently upon the need for localities to take a joined-up strategic approach to goal-setting, commissioning and response to results in order to embed a performance-enhancing way of working at all levels.

12. Critical Achievements

The feedback suggests that NST input was of value due to a combination of factors – including:

- The rapid senior engagement at Chief Executive, local Cabinet and Director level
- Demonstrable connectivity between DH and other Government Departments (especially DfE, DCLG, Home Office and Ministry of Justice)
- The listening skills of NST interviewing consultants
- Emphasis upon systematising and scaling-up services and interventions to make a real impact
- Attention to structure, systems and leadership issues
- Expertise in developing partnership working to enable public health delivery
- Specialist expertise and access to (and interpretation of) national and international evidence
- Practical recommendations to resolve locally identified deficiencies.
- Intensity and clarity of focus
- A supportive tone and style, acknowledging strengths but ready to challenge weaknesses
- Rapid, thorough, interesting feedback delivered in an inspirational and energising manner
- Acting as a catalyst for change

13. Reaching Milestones

The Sexual Health NST's activity, which focussed upon meeting clinical recommendations to offer access to professional GUM services within 48 hours of patient contact, demonstrated this effect quantitatively – localities receiving NST input improved by a greater degree (58%) than the England average (42%). The Alcohol Harm Reduction NST had a similar effect upon the numbers of alcohol-dependent people obtaining treatment; comparing April-September 2008 to the same period in 2009, a 41% increase in areas visited as opposed to 18% nationally.

Similarly, there has been a greater decrease in the average rate of under-19 conceptions for the Teenage Pregnancy NST visited areas since the launch of this team. Prior to the launch of the NST in 2007, the aggregate average decrease in those areas which the NST visited was just 1.1% from the 1998 baseline to 2007, and the rates were increasing. This compares with a decrease of 10.3% observed nationally over the same period.

In the period following the launch of the TPNST, those areas visited in 2007 experienced a greater average decrease, 4.4% overall, closer to the England average of 5.7% over the same period.

14. Developing Decision Support Tools

The HINST has developed and refined tools to estimate the number of people that need to be treated in any given population to achieve specific health outcomes for that population. For example, by drawing on research evidence and local epidemiological data, the team can model the number of people with CHD that need to be treated with specific primary care interventions to achieve potential reductions in CHD and stroke deaths.

15. Changing Thinking and Action

Independent evaluation half-way through the life of the NST project in 2008, covering the activity of the first four NSTs (Sexual Health, Tobacco Control, Health Inequalities and Teenage Pregnancy), showed that Chief Executives and Directors interviewed had already found the NST visits instrumental in focusing on the changes required to improve future results[8].

Recent evaluation carried out with senior leaders (Chief Executives and local authority / NHS Directors) in 59 localities visited by seven NSTs[9] revealed a remarkable assessment by NST clients:

- 94% of respondents felt that an NST visit raised the profile of the public health topic
- 92% identified that the input had aided the adoption of an evidence-based approach
- 88% of noted that the style and content of the NST visit had changed thinking in the organisation
- 86% would recommend an NST visit to peers

16. Conclusion

The NSTs demonstrated that change support provided to the frontline on behalf of a central Government department could be not only effective, but valued and welcomed to the point that it became a potential PR asset. The positive verbal feedback from clients at the close of NST visits was testimony to this, as were the many requests for return visits by localities that had been initially wary of an external team contributing. As an NHS chief executive in a locality visited by the Health Inequalities NST summarised the effect, it "…helped us to focus. It wasn't a way that we had been thinking." The statistics back that up; against the background of an increasing inequalities gap in the most deprived localities, localities which benefitted from early visits by the Health Inequalities NST slowed down the mortality trend in males and closed their female average life expectancy gap between 2005/7 and 2006/8[10.]

The NST methodology and process have clearly established an effective approach; as one Joint Local Authority/ PCT Director of Public Health put it "In the future this sort of help will

be even more important to focus on delivery of the new outcomes. We need to scrutinise at local level, share good practice from elsewhere and engage elected members much more."[11]

References

[1] Block, P (2000) *Flawless Consulting: A Guide to Getting Your Expertise Used*, 2nd edition San Francisco; Pfeiffer

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[3] Whitney, D Trosten-Bloom, A (2003) *The Power of Appreciative Inquiry; A Practical Guide to Positive Change* San Francisco; Berrett-Koehler

[4] Dannemiller, K and Jacobs, R (1992) 'Changing The Way Organizations Change: A Revolution Of Common Sense' in *The Journal of Applied Behavioral Science* Vol.28 No. 4 pp.480-498

[5] Anonymised client feedback cited in Hacker, J (2010) *Evaluation of the National Support Teams* Department of Health internal document

[6] Hacker, J (2010) *Learning from analysis of visit reports; all NSTs, 2009/10* Department of Health internal document

[7] Hacker, J (2010) *Learning from analysis of visit reports; all NSTs, 2009/10* Department of Health internal document

[8] Bell, M, Ross, S (2008) *Report on NST qualitative interviews* London, Quadrant Consultants

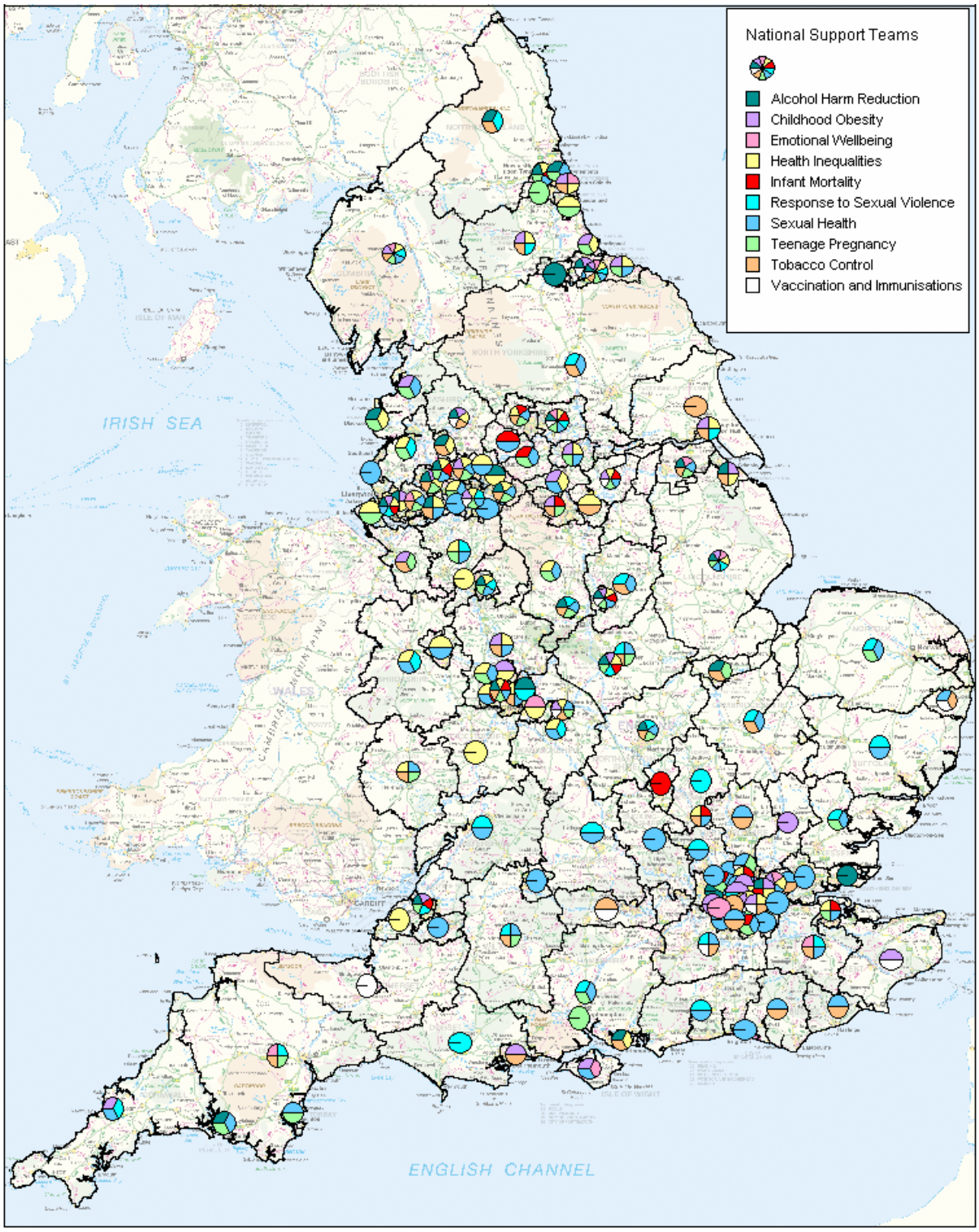
[9] Hacker, J (2010) *NST Evaluation final results* Department of Health internal document

[10] Hacker, J, Burton, C, Romeri, E (2010) *Evaluation of the Health Inequalities NST* internal DH document

[11] Anonymised client feedback cited in Hacker, J (2010) *NST Evaluation final results* Department of Health internal document

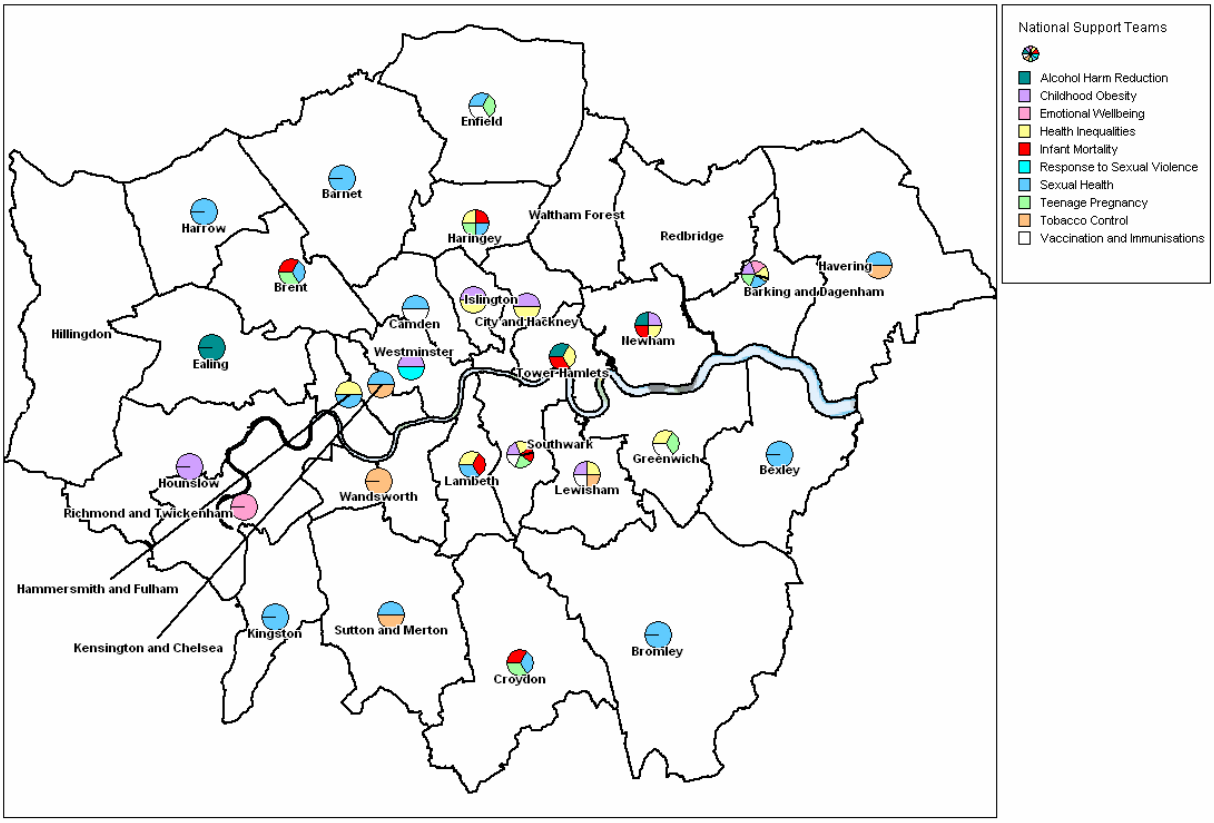
Appendix 1

Visits completed by 10 National Support Teams



Every PCT in England has been involved in a visit from at least one of the NSTs either directly or indirectly, as a part of an RSV visit to a police constabulary. This is because certain police constabularies cover numerous local authorities and PCTs.

The difference between the total number of visits per team (total A) and per area (total B) is due to the fact that some areas have had multiple visits from the same team, and that some areas received a visit from more than one team.



National Support Team	Nº of Visits
Alcohol Harm Reduction	34
Childhood Obesity	41
Health Inequalities	71
Infant Mortality	24
Response to Sexual Violence	37
Sexual Health	115
Teenage Pregnancy	59
Tobacco Control	47
Vaccination & Immunisation	17
Young People's Emotional Health & Wellbeing	13
Total	458

SHA Region	Nº of Visits
East Midlands	41
East of England	33
London	62
North East	40
North West	94
South Central	20
South East Coast	25
South West	31
West Midlands	55
Yorks & Humber	57
Total	458